WASHINGTON STATE RESPONDS

PROVIDING EDUCATIONAL INFORMATION ON HIV/AIDS & OTHER INFECTIOUS DISEASES AND REPRODUCTIVE HEALTH

NOVEMBER 2005

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The Washington State Department of Health HIV Prevention & Education Services, Client Services, and the Governor's Advisory Council on HIV/AIDS (GACHA) share a web address. Go to **www.doh.wa.gov/hiv.htm** for program access. You can also access the HIV Prevention & Education Services website at the old web address: **www.doh.wa.gov/cfh/hiv_aids/prev_edu/**.

Washington State Responds Quarterly Newsletter Now Electronically Distributed

Now that WSR is distributed electronically on our web site, we can send you an e-mail notification when the new issue is available online. In order to receive this notice please send your e-mail address with the subject title: **WSR E-List**. All you need to include in your note is your complete e-mail address. Please send to: **barbara.schuler@doh.wa.gov**.

HIV/AIDS Trainings to Meet State Licensing Requirements

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Anacortes (Skagit County)	(360) 299-1342 Jo Ann Hoover	4 hour 7 hour Video Courses	No charge	Offered by Island Hospital. For residents of Island, Skagit and San Juan Counties only.
Bellingham (Whatcom Co.)	(360) 733-3290	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $40 for 4 hour $60 for 7 hour	Offered by the Whatcom County-Bellingham American Red Cross.
Bellingham (Whatcom Co.)	(360) 715-8350	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 7 hour	Offered quarterly through Bellingham Technical College.
Bellingham (Whatcom Co.)	(360) 715-8350	4 hour Infectious Disease Prevention for EMS	$30 for 4 hour	Offered quarterly through Bellingham Technical College.
Bremerton (Kitsap County)	(360) 377-7307	4 hour 7 hour	$25 for 4 hour $30 for 7 hour	Offered by Kitsap Home Care Services Training Center.
Bremerton (Kitsap County)	(360) 475-7359	2.5 hour	$15 for 2.5 hour	Offered by Olympic College in Bremerton.
Bremerton (Kitsap County)	(360) 377-3761	2.5 hour 4 hour 7 hour	$21 for 2.5 hour $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Bremerton (Kitsap and Pierce Counties)	(360) 405-0430 (253) 474-5879	2 hour 4 hour	$15 for 2 hour $15 for 4 hour	Offered by instructor Francis Hall. Also available in Pierce County.
Clallam County (Port Angeles)	(360) 417-2352 K. McDaniel	2 hour	$10 for 2 hour	Offered by Clallam County Health Department.
Clark County (Vancouver)	(360) 693-5821	2 hour 4 hour 7 hour	$10 for 2 hour $20 for 4 hour $50 for 7 hour	Offered by the American Red Cross.
Clark County (Vancouver)	(360) 759-4404 **http://www.nwrtc.org**	7 hour 4 hour	$60 for 7 hour $50 for 4 hour	Northwest Regional Training Center.
Colville (Ferry, Stevens and Pend Oreille Counties)	1-800-827-3218 Angie	2 hour	No cost for 2 hour classes	Offered by Northeast Tri-County Health District.
Coupeville (Island County)	(360) 678-5151	4 hour 7 hour	Call for info	Offered by Island County Health Department and Whidbey General Hospital.
Edmonds (Snohomish County)	(425) 640-1840	7 hour	$89 for 7 hour Also receive one credit.	Offered by Edmonds Community College.
Everett (Snohomish County)	(425) –259-9899 Anne Miles; Ext. 16 **http:// www.pwnetwork.org/**	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 5 hour	Offered by Positive Women's Network.
Everett (Snohomish County)	(425) 252-4103 Laura; Ext.12	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $30 for 4 hour $60 for 7 hour	Offered by the American Red Cross. Scholarships are available.

HIV/AIDS TRAININGS TO MEET STATE LICENSING REQUIREMENTS, CONTINUED

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Grays Harbor	(360) 533-3431	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Grays Harbor and Pacific County	(360) 267-3404 (360) 267-3405	2 hour 4 hour 7 hour 10 hour	$30 for 2 hour $45 for 4 hour $75 for 7 hour $85 for 10 hour	Offered by Critical Incident Stress Management (CISM). They also offer First Aid/CPR classes.
Kirkland (King County)	(425) 739-8104 (425) 739-8112	7 hour	$69 for 7 hour	Offered by Lake Washington Technical College.
Mason County	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Mt. Vernon (Skagit County)	(360) 428-2151	4 hour 7 hour Videos	$25 handling fee for video tapes	Offered by Skagit Valley Hospital.
Mt. Vernon (Skagit County)	(360) 424-5291	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $35 for 4 hour $45 for 7 hour	Offered by American Red Cross.
Okanogan	(509) 422-7153	2 hour 4 hour 7 hour	$30 for 2 hour $30 for 4 hour $30 for 7 hour	Offered by Okanogan Health District.
Olympia (Thurston County)	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Olympia	(360) 352-2375	4 hour 7 hour	$30 for 4 hour $60 for 7 hour	Offered by United Communities AIDS Network (UCAN).
Puyallup (Pierce County)	(253) 841-3311	2 hour 4 hour 7 hour	$15 for 2 hour $40 for 4 hour $50 for 7+ hour	Offered by H.E.L.P. (HIV/AIDS Educational Learning Place) the C.P.R. First Aid Company.
San Juan County	(360) 378-4474	2 hour 4 hour 7 hour	$20 for 2 hour $20 for 4 hour $20 for 7 hour	Offered by San Juan County Health & Community Services.
Seattle/King Co. & South Snohomish Co.	(206) 784-5655 www.healthinfonetwork.org	2 hour 4 hour 7 hour	$10 for 2 hour $25 for 4 hour $40 for 7 hour	Offered by Health Information Network. They will also travel to your facility.
Seattle	800-783-2437	2.5 hour 4 hour 7 hour	$36 for 2.5 hour $44 for 4 hour $58 for 7 hour	Offered by Health Impact. Audio course available.
Seattle	(206) 726-3534	2 hour 4 hour 7 hour	$21 for 2 hour $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Seattle	(206) 850-2070 Betty Morgon aarthministry@yahoo.com	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $45 for 4 hour $60 for 7 hour	African Americans Reach and Teach Ministries (AARTH)
Spokane	(509) 326-3330 Ext. 210	2 hour 4 hour	$20 for 2 hour $30 for 4 hour	Offered by the American Red Cross.
Spokane	(509) 324-1542	7 hour	$50 for 7 hour	Offered by the Spokane Regional Health District.

HIV/AIDS Trainings to Meet State Licensing Requirements, continued

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Spokane	(509) 928-1588 Ext. 16	7 hour	$45 for 7 hour	Offered by Visions Community Resources.
Spokane	(509) 236-2430 Becky Nauditt	2 hour 4 hour	$18.00 $30.00	Offered by Becky Nauditt
Tacoma (Pierce County)	(253) 841-3311 Barbara Miller	2 hour 4 hour 7 hour	$30 for 2 hour $40 for 4 hour $50 for 7 hour	Offered by C.P.R. Company.
Tacoma (Pierce County)	(253) 474-0600	2 hour 4 hour 7 hour	$15 for 2 hour $43 for 4 hour $55 for 7 hour	Offered by the American Red Cross.
Tacoma (Pierce County)	(253) 566-5020 Linda Finkas	7 hour 7 hour Independent Study	$40 for 7 hour $45 for video course	Offered by Tacoma Community College.
Vancouver	(360) 992-2939 Press Option One	2 hour 4 hour 7 hour	$30 for 2 hour $50 for 4 hour $60 for 7 hour	Offered by Clark College Continuing Education Program. Take home program that offers discounts for 2 or more students.
Walla Walla	(509) 527-4330	7 hour	$45 for 7 hour	Offered quarterly by Walla Walla Community College.
Wenatchee	(509) 664-3475	4 hour 7 hour	$20 for 4 hour $35 for 7 hour	Central Washington Hospital
Whitman County (Colfax)	(509) 397-6280	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
Whitman County (Pullman)	(509) 332-6752	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
White Salmon (Klickitat County)	(509) 493-1101	2 hour, 4 hour, 7 hour and other First Aid classes	$25 for 2 hour $30 for 4 hour $50 for 7 hour	Offered by Skyline Hospital.
Yakima	(509) 248-3628	7 hour	$50 for 7 hour	Offered by Planned Parenthood of Central Washington.
Yakima	(509) 457-1690	2 hour	$20 for 2 hour	Offered by the American Red Cross.
Yakima	(509) 853-2034 or 1-877-620-6202 http://www.fas-training.biz/	4 hour 7 hour and other First Aid classes	$40 for 4 hour $55 for 7 hour	Offered by First Aids & Safety Training.

HIV/AIDS Trainings to Meet State Licensing Requirements, Statewide

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Statewide	(206) 784-5655 http://www.healthinfonetwork.org/	HIV/AIDS 7-hour Video Course	$250	Offered by Health Information Network. Designed to assist health care facilities meet Washington State Licensing requirements.
Statewide	(206) 543-1047	HIV/AIDS Training Course on DVD	$95 for 7 hour	Offered by U of W School of Nursing. Designed to assist health care facilities to meet WA State requirements.
Statewide	(425) 564-2012 www.bcc.ctc.edu	HIV/AIDS Self Study Program $100 Refundable Deposit	$60 for 4 hour * $80 for 7 our *includes mailing	Offered by Bellevue Com. College Continuing Nursing Education and Health Information Network.
Statewide	(206) 320-9822	2 hour 4 hour 7 hour	$30 for 2 hour $45 for 4 hour $65 for 7 hour	Offered by the Empowerment Institute. Course may be offered at your site.
Statewide Internet Classes	(707) 937-0518 www.nursingceu.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Washington State HIV/AIDS internet course offered by Wild Iris Medical Education.
Statewide Internet Classes	1-800-346-4915 www.classesonline4u.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Online course offered by Prevention MD. 2 hour course offered in Spanish.
Statewide Internet Classes	(509) 628-1317 Kathleen Hayes www.designerwebsitesolutions.com	4 hour 2 hour	$40 for 4 hour $20 for 2 hour	Online course offered by Designer Website Solutions.

HIV Prevention Counseling and Testing Training Schedule for 2004-05

These one-, two- and three-day courses will assist health care providers and others develop necessary skills for providing pre- and post-test counseling for HIV testing, as required by Washington State law.

These courses are not intended for the general public.

Region	Trainer	Course Dates	
One (Spokane)	**Christopher Zilar** (509) 324-1542 The cost varies according to length of class.	Oct. 12-13, 2005 Mar. 14, 2006	(3 day) (1-day)
Two (Yakima)	**Deborah Severtson-Coffin** (509) 454-3322 The cost for the 2-day class is $85.	Oct. 27-28, 2005	(2 day)
Three (Everett)	**Eric Hatzenbuehler** **Jordan Bower** (425) 339-5275	Nov. 28-30, 2005	(3 day)
Four (Seattle)	**Robert Marks and Mark Alstead** (206) 296-4649 or e-mail to: diane.ferrero@metrokc.gov The cost for the 2-day class is $125. The cost fot the 3-day class is $175.	Oct. 18-19, 2005 Feb. 14-16, 2006	(2 day) (3 day)
Five (Tacoma)	**Kim Ingram** and **Moni Muraki** (253) 798-2939 The cost varies according to length of class.	Oct. 26-28, 2005	(3-day)
Six (Vancouver)	**Beth McGinnis** (360) 397-8111	Oct. 26-28, 2005	(3 day)

Calendar

November 9, 2005

Washington Statewide Collaborative HIV/Hep C Conference is being held on November 9 and 10, 2005 at LaQuinta Inn, 32124 25th Avenue South, Federal Way, Washington. Some of the topics will be: Medicare and the Evergreen Health Insurance Program (EHIP); Ask, Screen, Intervene: Incorporating HIV Prevention into the Medical Care of persons living with HIV; The Basics of Tuberculosis; The ABC's of Hepatitis C; The Evergreen Health Insurance Program (EHIP); The STD and HIV Connection; Immigrant Eligibility for Health Care; and, Partnering with HCV Advocacy Organizations. For more information, please call Sharon Rockwood at (206) 417-7776. For conference registration forms, call Evelyn Linton at (360) 236-3453. Registration must be faxed or sent by United States mail; registration deadline is October 21; however, applications will be continued to be accepted as long as the conference has not met attendance capacity.

December 1, 2005

WORLD AIDS DAY

World AIDS Day is a day of action on HIV and AIDS, held annually on December 1, and supported by year round campaign activity. The 2005 theme is '**Stop AIDS. Keep the Promise**'. The goal of the campaign is to help create an effective and sustained response to the AIDS epidemic through national and international partnership. Public awareness of past policy commitments and promises on AIDS is crucial to the success of the campaign; in particular, awareness of the Declaration of Commitment on HIV/AIDS. These are policy commitments for which the campaign aims to hold governments accountable. To learn more, please go to: **http://www.hpvpi.org.yu/new/WAC%20Overview%20note%202005.pdf# search ='world%20aids%20day%202005%20stop%20aids%20keep%20the%20promise'**.

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Come to a World AIDS Day Benefit Luncheon on Thursday, December 1st, 12:00 p.m. at the Washington State Convention and Trade Center, Ballroom A, 800 Convention Place, Seattle. This benefit luncheon for Multifaith Works will showcase the mission and service of Multifaith Works to people living with AIDS, MS or other life threatening illnesses over the last 17 years. Guest speaker will be Dr. Charles Garfield, founder of the Shanti National Training Institute in San Francisco. For information and registration, please contact Gary Southerton at (206) 324-1520 x229 or **gary@multifaith.org**.

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The Pierce County World AIDS Day event is a day of action held annually in Tacoma with HIV and AIDS events including music, entertainment and the voices of people living with HIV/AIDS. The event also celebrates the efforts to combat the global AIDS epidemic. A location has yet to be announced. Please contact **rbatten@piercecountyaids.org** for more information, or visit their website at **www.piercecountyaids.org**.

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World AIDS Day Luncheon benefiting AIDS Housing of Washington will be held at Seattle's Westin Hotel on December 1, 2005 from 11:30 a.m.-1:00 pm. Contact Maria Zazychi at (206) 322-9444 or email **Maria@aidshousing.org**.
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December 5, 2005

Funding Available for the Evaluation of HIV Testing to African-American Women with Undiagnosed HIV Infection: Application Deadline is **December 5, 2005, 4:00 p.m. (EST).**

The Centers for Disease Control and Prevention (CDC) is announcing Funding Opportunity Number: **RFA #AA016—"Evaluation of the Relative Effectiveness of Four Public Health Strategies for Providing HIV Testing to High-Risk African-American Women with Undiagnosed HIV Infection."** The purpose of the program is to evaluate multiple strategies for reaching and providing HIV counseling, testing, and referral services to African-American women at high risk for HIV, thus increasing the proportion of those who know their HIV status. Although this program is primarily focused on African-American women, other high-risk women reached through these efforts should not be denied HIV testing, counseling, and referral services funded under this program regardless of race or ethnicity. View CDC Funding Announcement RFA #AA016 at http://www.fedgrants.gov/Applicants/HHS/CDC/PGO /CDC-RFA-AA016/Grant.html.

December 8, 2005

Basic STD Overview for Non-Clinicians - This free one-day training provides a basic overview of the clinical aspects of STDs for people working in STD/HIV prevention and education. After completing this course, participants will be able to: describe common STDs and their symptoms, summarize STD trends locally and nationally, describe the relationships between HIV and other STDs, and describe which behaviors are high-risk for STD infection. This course is for non-clinicians, counselors, case managers, outreach workers, teachers, health educators, church health ministers, youth workers and others involved in or new to STD and HIV prevention. Please go to www.stdhivtraining.org to apply online. You may also contact Amy Radford at the Seattle STD/HIV Prevention Training Center at (206) 616-7516 or email aradford@ u. washington.edu.

Support Groups

HIV/AIDS Support Group: This is an ongoing emotional support group for anyone who is HIV positive or who has AIDS, and meets Mondays from 6:00 p.m.- 7:30 p.m. Drop-ins are welcome to attend this group; drop in by 6:00 p.m. at 303 17th Ave East, Seattle. If you would like more information, please call the Dunshee House at (206) 322-2437.

HIV Positive Support Group: This is a new emotional support group for anyone newly diagnosed HIV positive. The group is especially welcoming of and helpful to those who are newly sero-converted. The support group meets Wednesdays, 7:30-9:00 p.m. Drop-ins are welcome to attend this group; drop-in by 7:30 p.m. at 303 17th Ave East, Seattle. If you would like more information, please call the Dunshee House at (206) 322-2437.

BABES Network YWCA is a peer-support program, a sisterhood of women facing HIV together. BABES Network provides peer support, advocacy, education, and outreach programs for women facing HIV. Volunteers are always needed in: childcare, computer training, technical assistance, executive assistant, fundraising, letter writing, office assistance and Spanish translation. Please call (888) 292-1912 for more information.

Volunteer Opportunities

Volunteers are needed as one-on-one mentors, summer camp counselors and camp program staff. **Rise n' Shine's** service area includes children and teens affected by HIV and AIDS living in King, Pierce, Snohomish and other Puget Sound counties. Stable, compassionate and giving individuals are needed to volunteer with this special group of children. The next new volunteer training is scheduled for November 5th and 6th. For a volunteer application and information, please contact Danica Smith at (206) 628-8949 ext. 210 or e-mail **Danica@risenshine.org**.

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Shanti Volunteer Training is on November 5, 6, 12 and 13, 2005. Volunteers provide one-on-one, nonjudgmental emotional support to people living with HIV/AIDS, cancer, MS, and other life-threatening illnesses. The Shanti training and volunteer experience has been described as life-changing for many volunteers. For more information, please call (206) 324-1520 ext. 3 or e-mail shanti@multifaith.org.

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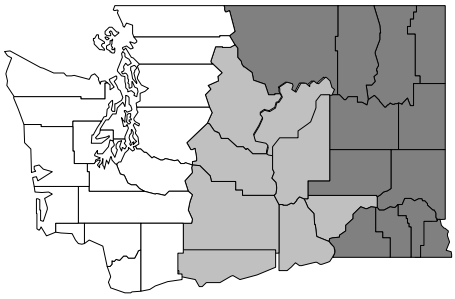
BABES Network YWCA is a peer-support program, a sisterhood of women facing HIV together. BABES Network provides peer support, advocacy, education, and outreach programs for women facing HIV. Volunteers are always needed in: childcare, computer training, technical assistance, executive assistant, fundraising, letter writing, office assistance and Spanish translation. Please call (888) 292-1912 for more information.

Regions 1 & 2



Region One (dark area) includes Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman Counties. The Region One AIDSNET Office is in Spokane and the Coordinator is Barry Hilt at (509) 324-1551.

Region Two (gray area) includes Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat and Yakima Counties. The Region Two AIDSNET office is in Yakima and the Coordinator is Wendy Doescher at (509) 249-6503.

Transitions

Yakima County would like to welcome **David Miller, RN.** David will head the Prevention for Positives program in Region 2. He will also take the lead in Partnership for Health and train clinics on prevention for HIV positive clients. David also works with physicians at needle exchange and does wound care as well as teaches clients how to take care of their own abscesses.

Announcements

Spokane Outreach Services are provided by public health professionals through two locations. The first location is the **Outreach Center** located at 1103 W. First Avenue and is open Monday through Friday from 3:00-5:00 p.m. Donated items such as clothing, toiletries, small household items and holiday gifts are distributed to clients. Call (509) 838-6859 for information.

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The second location is the **Outreach Mobile** van located in areas of Spokane frequented by individuals at highest risk for contracting HIV. Outreach Mobile services include: needle exchange (free one for one exchange of used needles for clean needles is offered to injection drug users) and condom distribution, as well as other HIV prevention supplies including: bleach kits, lubricant, alcohol pads, cotton swabs and referral and education services.

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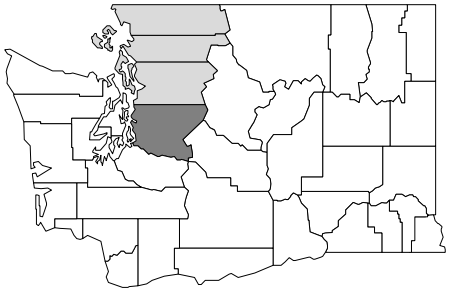
Yakima County HIV staff continue to offer education to the farm-working community as well as in the county jails and drug treatment centers; staff offers testing for those that are at high risk for acquiring HIV. Needle Exchange is serving larger numbers of people, and is starting to see an increased number of youth. Yakima continues to staff two exchange sites, one during the day and the other in the evening; contact program staff at (800)-535-5016 for time and location. Yakima Health District offers free HIV testing for high risk individuals every Wednesday from 10:00 a.m. – 4:00 p.m.

Regions 3 & 4



Region 3 (gray area) includes Island, San Juan, Skagit, Snohomish and Whatcom Counties. The Region 3 AIDSNET office is in Everett and the Coordinator is Alex Whitehouse at (425) 339-5211.

Region 4 (dark area) is King County. The Region 4 AIDSNET office is in Seattle and the Coordinator is Karen Hartfield, who can be reached at (206) 296-4649.

Transitions

Public Health Seattle and King County's Mark Alstead and **Robert Marks** will no longer be conducting the HIV Testing/Prevention Counseling Workshops; Robert Marks and Mark Alstead have moved into supervisory positions at the STD Clinic at Harborview and at Jail Health Services, respectively. **Kathy Silverman** and **Bill DeYoung** will be the new facilitators for the Region 4 Washington State HIV Test/Prevention Counseling workshops. Kathy is an educator consultant with the HIV/AIDS Program. Kathy is a very talented trainer and previously facilitated these workshops for 6 years. Bill is a highly skilled disease intervention specialist at the STD Clinic at Harborview.

Announcements

POCAAN's T-Time (Transgender Time) provides: free HIV testing and counseling; referrals for clothing and housing; continued education and training; self esteem workshops; and, free food and possible employment or volunteer opportunities for transgender women of all ages. Other services include equal access to health care and treatment for chemical dependency. The workshops are held in English and Spanish at 2200 Rainier Ave. S., Seattle. For more information call (206) 322-7061 x225.

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Holiday Giving: Rise n' Shine is a local non-profit that provides support for children and teens affected by HIV and AIDS. Each year the children of Rise n' Shine wish for 3 wants and 3 needs for the holidays, often times these are the only gifts these children will receive. Sponsors are needed to provide gifts for these children and teens. If you are interested in sponsoring a child or making a donation, please contact Michael Dunlop at (206) 628-8949 ext. 229, e-mail **Michael@risenshine.org** or visit **www.risenshine.org**.

POCAAN's 4 Every Man is an intervention that addresses the African American male population's perception of risk for acquiring HIV. This intervention is based on the Popular Opinion Leader (POL) model, which consists of a group of trusted, well-liked people who are recruited and trained to conduct a specialized type of outreach. This outreach includes endorsement of safer sexual behaviors in casual, one-on-one conversations with peers in their own social network at a range of venues and settings. For more information, call (206) 322-7061 ext. 223, or contact Kenny Joe McMullen at **kenny@pocaan.org** or Kiande Jakada at **kiande@pocaan.org**.

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HIV Wellness Seminars are Dunshee House's free wellness workshops for people living with HIV/AIDS. The seminars are offered Wednesdays, 6:00 p.m.-7:30 p.m. For information on the fall seminar schedule, please call Jamie at (206) 322-2584.

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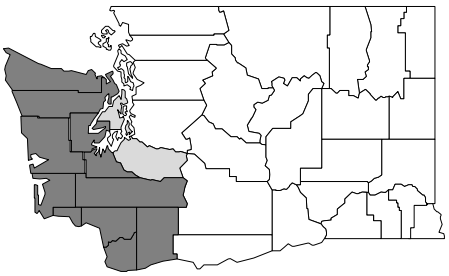
"Gathering @ Kenny Joe's Place" is a venue for bringing African American men together from various backgrounds to share their stories, knowledge and concerns about HIV and how it affects their lives. This gathering is also a great opportunity to meet new brothers and to identify potential POL in this safe social environment. This gathering takes place the third Sunday of each month at 6:00 pm. Contact: Kenny Joe McMullen, program manger, at kenny@pocaan.org; or call (206) 322-7061 x223.

Regions 5 & 6



Region 5 (gray area) includes Kitsap and Pierce Counties. The Region 5 AIDSNET office is in Tacoma and the Coordinator is Mary Saffold at (253) 798-4791.

Region 6 (dark area) includes Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum Counties. The Region 6 AIDSNET office is in Vancouver and the coordinator is David Heal at (360) 397-8086.

Transitions

Clark County's Brent Stubblefield, transferred from Clark County's HIV Prevention Services in the summer of 2005 to become their new **HIV case manager**. Brent has been with the county for 3 years.

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Clark's HIV Prevention Specialist, Shawn Ryan, MSW, started at the health department in September 2005. His primary focus will be on an individual-level Prevention with Positives program. Shawn comes from NY State.

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Clallam County said **goodbye to Lyell Fox**, Syringe Exchange Nurse, in September. Lyell is returning to a midwifery practice.

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Jeremy Wekell, Community Educator, is leaving PCAF to accept a position with a drug treatment program in Port Orchard. Case manager **Trina Hall** has accepted a position working with domestic violence victims in the Pierce County Prosecutor's Office. **Craig Ross** is joining the staff as the Director of Finance and Administration.

Announcements

AIDS Housing Association Project Open Door: The Tacoma Project Open Door house is open and three formerly homeless people living with AIDS are now living in their new home. A second home will open soon. In all, eight people will receive housing. For more information about the houses call either Karen Leitch at AHAT (253) 272-5533 or Tim Menard at PCAF (253) 383-2565.

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The Pierce County AIDS Foundation (PCAF) is offering Volunteer Attorneys for Persons with HIV/AIDS legal access (VAPWA) for estate planning and other civil legal needs through the King County Bar Association and the Tacoma Pierce County Bar Association. Please call (253) 383-2565 to set up an appointment or just drop by PCAF from 2:00 p.m. to 4:00 p.m. on October 20, November 17 or December 15, 2005.

Free Hepatitis A&B shots are offered at the Tacoma-Pierce County Health Department on Tuesday's from 1:00 p.m.-

4:00 pm for the following: men who have sex with men and their partners; sex workers and their partners; and, injection drug users and their partners.

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The Oasis Youth Center (OASIS) is Pierce County's drop-in support center for lesbian, gay, bisexual, transgender and questioning youth ages 14-24. Oasis is coordinating Washington's first **youth-led tobacco education program for LGBTQ youth**. Supported by funding from the Verbena Health Center and the Tacoma/Pierce County Health Department, **"Queers Kick Ash"** is designed to provide culturally relevant outreach materials to all Oasis youth through support for smokers who want to quit, as well as smoke-free social opportunities. Youth who attend QKA meetings learn about the tobacco industry's targeted marketing campaigns, stress relieving techniques and receive support and resources for becoming and remaining smoke free. Oasis is proud to be on the forefront of a smoke-free queer community.

Oasis will also be hosting its **6th annual HIV Prevention and Education retreat** in mid-November. **"Raise the Flag"** will feature workshops on community-building, HIV education, and healthy relationships. For more information about Oasis programs, please (253) 671-2838 or contact **oasisyouthcenter@hotmail.com.** Oasis is a program of the Pierce County AIDS Foundation.

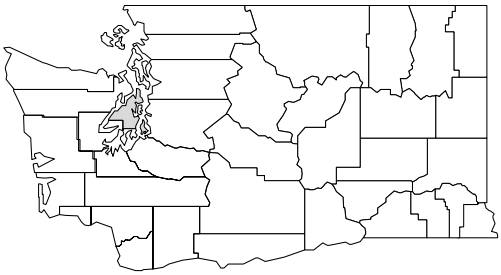
SERGIO REY FERNANDEZ FLORES, MD

October 25, 1959 – September 21, 2005

The Pierce County AIDS Foundation lost former colleague Sergio Fernandez. Sergio served on the PCAF staff from 2001-2004 as a community educator and client support specialist before returning to his family home in Mexico.

Statewide News

Announcements



The **Greater Seattle Business Association (GSBA)** and the **Pride Foundation** have **$250,000 in scholarships available** for lesbian, gay, bisexual, transgender, questioning, straight ally (straight and supportive of LGBT issues) students of all ages, as well as students from LGBT families. There are forty different types of scholarships with awards of up to $10,000 – but only one application to complete. For more information about this unique opportunity go to www.thegsba.org/scholarships or call 1-800-735-7287

State Planning Group

The State Planning Group (SPG) is scheduled to meet the 4th Thursday of the month from 9:00 A.M. to 2:30 P.M. in SeaTac, Washington. ***For confirmation of dates and times, please check with Harla Eichenberger at (360) 236-3424*** or visit: http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/hiv_comm_plan.htm.
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COMMUNITY PLANNING

The six **AIDSNET Regions** continue to coordinate the local planning process through meetings of the Regional Planning Groups (RPGs). This process absolutely requires input and participation from members of the community infected and affected by this epidemic. Are you willing to become one of the voices that support effective prevention efforts? If so, please contact your local Regional Coordinator or DOH contact in the list below, for more information.

Barry Hilt - Region 1 AIDSNET (Spokane) – (509) 324-1551

Wendy Doescher – Region 2 AIDSNET (Yakima) – (509) 249-6503

Alex Whitehouse – Region 3 AIDSNET (Everett) – (425) 339-5211

Karen Hartfield – Region 4 AIDSNET (Seattle) – (206) 296-4649

Mary Saffold – Region 5 AIDSNET (Tacoma) – (253) 798-4791

David Heal – Region 6 AIDSNET (Vancouver) – (360) 397-8086

Brown McDonald – State Planning Group (SPG) – (360) 236-3421

HIV Prevention Focus

Intervention in the Spotlight

Partnership for Health: Clients and Providers Working Together

In June, I had the opportunity to attend a "Partnership for Health (PfH)" train-the-trainer workshop presented by Maggie Hawkins, Project Coordinator and Jony Weiss, Project Lead Trainer, from Keck School of Medicine, University of California. Following the intervention information presented in the published article, I will provide a brief discussion about the workshop.

Intervention Type: Individual-level Intervention

Risk Transmission Category: HIV Positive Clients

Behavior Placing Them at Risk: Unprotected Sex

Setting: Health Care Practitioner's Office

Study Title: "*Effect of brief safer-sex counseling by medical providers to HIV-1 seropositive patients; a multi-clinic assessment*". Jean L. Richardson, Joel Milam, Allen McCutchan, Susan Stoyanoff, Robert Bolan, Jony Weiss, Carol Kemper, Robert A. Larsen, Harry Hollander, Penny Weismuller, Chih-Ping Chou, and Gary Marks. AIDS 2004, 18:1179-1186.

Article Description:

INTERVENTION INTRODUCTION

Information gathered showed that many people diagnosed with HIV continue to engage in sexual activity. These same reports showed that many HIV positive people practice safer sexual behavior. The article provided the prevalence of unprotected anal or vaginal intercourse (UAV) and the number of partners for those participants who completed the baseline interview. The article also displayed the information according to the control group and the two message framing intervention groups (message framing will be described in detail later).

	Attention-control (n =190)	Gain-frame (n = 172)*	Loss-frame (n = 210)*
One baseline sex partner	20% (25/127)	26 % (33/128)	32% (38/118)
Two or more baseline sex partners	54% (33/63)	39% (17/44)	53% (49/92)

* The sample sizes do not equal 585 due to deletion on homosexual women and a few cases of missing data.

The article stated that until fairly recently, prevention programs were directed towards reducing risky behavior among HIV negative persons. There had not been many research projects which had high-risk HIV positive persons as their priority population, even though we all know that for a person to become infected with the HIV virus, at least one of the persons engaging in risky behavior must be HIV positive. The article quoted several sources which provided information concerning the percent of unprotected sexual intercourse which may potentially contribute to the spread of HIV. Reported prevalence of unprotected intercourse for HIV positive MSM ranged from 10% to 46%; the prevalence for unprotected vaginal intercourse in HIV positive women ranged from 37% to 52%. Studies have shown that health care providers were successful in assisting clients to change risky health behaviors (e.g. poor diet, smoking) and it was thought that the providers also might be helpful in assisting HIV clients to reduce their risky behaviors.

STUDY DESIGN

The theoretical framework for this intervention was the Social Cognitive model. The purpose of the study was to examine the effectiveness of framing safer sex messages that would be delivered to HIV positive clients during regularly scheduled medical appointments. These same messages would also be delivered to the clients in writing. Messages provided to the clients would be either in an advantage-frame (gain-frame) or consequence-frame (loss-frame); both message frames can be delivered in a caring manner. Depending on the client and the behavior in need of change, the impact may be different. Until this study, message framing had not been utilized in promoting safer sex practices with HIV positive persons. It was not known which framing method would be the most effective in promoting a change in risky behavior.

This controlled study involved six clinics in California. Two clinics used advantage-frame messages, two utilized consequence-frame messages, and two provided an intervention to enhance medication adherence (attention-control protocol). Prior to conducting the framed message intervention, staff at the clinics conducting the intervention were trained to deliver the messages. The Institutional Review Boards for each clinic and the Center for Disease Control and Prevention approved the procedures. The National Institute of Mental Health also issued a Certificate of Confidentiality to each of the six sites.

RECRUITMENT AND ELIGIBILITY CRITERIA

Clients for the study were recruited in 1998 and 1999; the intervention was actually conducted from 1999-2000. Of the 2,027 clients originally approached to participate in the study, 886 clients were found to be eligible and agreed to participate in the study. Eligibility criteria were:

- Aware of one's own HIV positive status;
- Sexually active during the three months prior to participation (mutual masturbation, oral, anal, or vaginal sex);
- 18 years or older;
- Fluent in Spanish or English;
- Able to provide written consent; and
- Intending to obtain care at the clinic for the next year.

Each eligible client was interviewed in a private room. If desired, the client was permitted to answer the behavior questions directly on the questionnaire rather than providing a verbal answer. Medical providers were not involved in collecting the data from the questionnaire. Measures on the questionnaire focused on the partner specific sexual behaviors during the three

months prior to the interview. There were six partner categories for which clients answered questions. They were: main partner, casual partners, and exchange partners (each category requested the gender of the partner). Participants used a checklist to outline the sexual practices (with and without a condom).

Control Conditions, Intervention, and Training

Two clinics, considered as control, focused on medication adherence. The attention-control group conducted a training similar to a safer sex intervention. The training used the same type of materials and counseling. They also used tailored medication schedules.

A total of four clinics conducted the Partnership for Health (PfH) intervention; two of the clinics presented advantage-framed messages and two presented consequence- framed massages. This approach was instituted to help patients stay as healthy as possible. Providers discussed the partnership idea with the client and administered advantage-frame or consequence-frame messages. The brief 3-5 minute counseling messages were delivered to the clients during each visit, except visits dealing with acute illness. Each discussion centered on safer sex goals and risk-reduction behaviors. Each client also received an incentive for participating in each interview. Providers were asked to provide documentation in the chart when they discussed safer sex (not client's sexual behavior).

Prior to conducting the intervention, all clinic staff attended a 4 hour training session to understand the intervention. The staff attended a booster session 1 month after the implementation of the intervention. The advantage-frame and consequence-frame messages were delivered over a period of 10-11 months. The initial training consisted of six main topics. The topics were:

1. Background and rational for the intervention;
2. Behavior change theories;
3. Communication skills;
4. Presenting brief counseling and communication advantage or consequence frame messages;
5. Safer sex role play counseling; and
6. Program implementation and referrals.

Each of the clinics received and distributed similar information concerning the program, to include advantage and consequence framed messages. The only activities which differed from one intervention clinic to another were the verbal counseling and the delivery of advantage-framed versus consequence-framed messages.

Outcomes

A total of 585 participants completed the follow-up survey. Those interviewed reported how often their health care provider discussed safer sex behavior during their visits. Clients in the advantage-frame and consequence-frame setting were more likely to report that their physician talked with them about safer sex behaviors half or more of their visits than those clients participating in the attention-control intervention. The same pattern was displayed when they were asked questions about receiving safer sex communication from other health care providers (nurse, nurse practitioner or physician's assistant). These results illustrate that the safer sex protocol (advantage and consequence message framing) led to frequent discussions concerning safer sex behavior in the non control group clients.

Among the clients with one partner at baseline participating in the intervention, the prevalence of unprotected anal or vaginal (UAV) intercourse did not show a significant change in any of the three intervention conditions. However, among those with two or more partners at baseline, UAV decreased 4% in the attention-control and increased 10% in the advantage framing intervention. The researchers indicated that this may reflect nothing more than measurement error. In the consequence message framing intervention, UAV reduced by 38% at the follow-up interview. The reduction was comparable for sex partners who reported being HIV negative/unknown (35% lower) and sex with partners who reported to be HIV positive (32% lower). The article clearly stated that clients with one sexual partner were not affected by either the consequence- or advantage- framed intervention. However, clients with multiple partners reduced their risky sexual behavior when they participated in the consequence- framed intervention, but not in the advantage- framed message intervention.

The researchers felt that counseling of couples may be needed to reduce risky sexual behavior when clients are involved in a stable relationship. When it involved an individual decision, the researchers also felt that the consequence- framed message interventions may be more effective for clients when changing risky sexual behavior.

The findings were also viewed in the context of limitations of the study. They were:

- The source of the motivation to change behavior could not be specified.
- They could not separate the contribution of the written materials from the counseling that was provided.
- Bias (self-reporting) could have influenced the outcomes. Their methodology attempted to minimize that effect.
- Effects of the consequence framed message intervention could depend on the clinic or provider delivering the intervention.

In 2004, the Washington State Planning Group selected HIV positive persons as the population about which they wanted to find out prevention needs. The Washington State Department of Health conducted the "HIV Infected Individuals Needs Assessment for HIV Prevention". A total of 195 HIV clients from around the state interviewed. As you will see from the three questions below, asked of HIV positive clients in Washington State, their responses are in line with what the article stated. Three of the questions asked were:

1. Who did you receive HIV information from in the last 12 months?

Doctor - 96% received services and 59% received HIV information;

Other medical (nurse) - 95% received services and 25% received HIV information; and

HIV care case Managers – 91% received services and 46% received HIV information.

2. Who would you most want to assist you with your HIV prevention needs?

Doctor - 38%

HIV care case Manager - 31%

Other medical (including nurses) - 4%

HIV prevention case managers - 3%

3. If you want to participate in an HIV prevention activity, what type would you most prefer?

-45% one-to-one sessions and 32% group session.

CLOSING

The intervention clearly demonstrated that counseling and message framing is realistic, can be accomplished by the provider, and can help reduce the risky behavior of HIV positive clients. For those who desire to reach HIV positive persons, you might want to consider using this intervention. The other unique opportunity about instituting this intervention is it provides an opportunity to collaborate with the health care providers in your area who treat HIV positive persons. To maintain fidelity and ensure effectiveness of this intervention, you **must** remember to maintain the core elements. After reviewing available materials, the 9 core elements are:

1. Deliver the intervention to HIV positive clients in HIV outpatient clinics;
2. Clinics adopt prevention as an essential component of patient care;
3. Train all clinic staff to facilitate integration of the prevention messages delivered;
4. Display posters in waiting areas and hand out brochures to clients that reinforce education and prevention messages;
5. Build on the ongoing relationship between the client and the provider;
6. Deliver brief 3-5 minute focused safer sex messages (self-protection, partner-protection, and disclosure);
7. Incorporate good communication techniques and use consequence-frame messages;
8. Provide referrals for needs that require more extensive counseling and services; and
9. Integrate prevention messages into clinic visits to every client on every visit.

Train-the-Trainer Workshop

I attended a Partnership for Health train-the-trainer workshop conducted on the 23rd and 24th of June 2005. The purpose of the workshop was to provide the skills necessary to conduct the 4 hour training for providers interested in implementing the PfH intervention. Jony Weiss, Project Lead Trainer and Maggie Hawkins, Project Coordinator, from the Department of Medicine, Keck School of Medicine, University of California, conducted the training. Both of these educators have been extensively involved with the intervention since its inception and work very closely with Jean Richardson, Dr. P.H., Professor/Principle investigator.

The majority of day one, Jony and Maggie presented a the 7 modules of the actual training as if we worked in a provider's office and were going to be conducting the intervention. They also laid the ground work for the intervention, reviewed the training manual, talked about adult learning, discussed how to adapt this intervention for case managers, and talked about the mock training.

The second day was primarily used for the participants to practice presenting the information as if they were conducing the intervention teaching session. Each participant selected a module to teach (there were two participants for each module). Modules were delivered to the group and the presenters received written feedback from the other participants concerning the presentation. Some of the take home messages I took from the June training were:

- ✓ Change is a process which occurs over time.
- ✓ Relapse is a part of change.

- ✓ Having knowledge does not always lead to change.
- ✓ Use consequence- framed messages for high risk clients.
- ✓ Consequence is reality based.
- ✓ Use active listening with clients.
- ✓ Clients should receive messages during every visit.
- ✓ Role play is essential in the training.
- ✓ Three messages that should be stressed and reinforced:

  Protect yourself, through safer sex;

  Protect your partner, through safer sex; and

  Disclose your status to you sexual partner

Elizabeth McGinnis Health Educator for Region 6 coordinated the training. Fourteen participants from different areas of the state attended the workshop; they were:

Region 1 - John Arvan and Diane Marr-Longmire;

Region 2 - David Miller, Carlos Contreras, and Melissa Baughman;

Region 3 - David Bayless & Janet Ballard;

Region 6 - Elizabeth McGinnis & Ben Johnson;

Harborview Medical Center, Madison Clinic - Seattle - Dennis Torres;

Group Health Cooperative – Seattle - Steve Carzasty;

Northwest AIDS Education Training Center–Seattle - Robert Carroll; and

Department of Health - Client Services - Monique Ossa.

You have read about the intervention as it appeared in the published article and I presented a condensed version of the training you must receive prior to implementing this intervention. The intervention in the spotlight this month offers a unique opportunity to get additional information from multiple sources.

The contact for the original article is: Jean Richardson, Department of Preventive Medicine, Keck School of Medicine – USC, 1441 Eastlake Ave, MS 9175, Los Angeles, CA 90033. You may view additional information at Partnership for Health: http://www.usc.edu/schools/medicine/departments/preventive_medicine/divisions/behavior/research/partnershipforhealth/intro.php.

You may also review an intervention in the Procedural Guidance at: http://www.cdc.gov/hiv/partners/AHP/CBOProcedures_15Dec03_FinalDraft.pdf. released in 2004 by CDC with the CBO program announcement. In the *Guidance, the intervention is* called "*Implementation of Integrating Prevention Services into Medical Care for People Living with HIV".*

If you would like to schedule an implementation training session, contact your regional coordinator to get the contact information of the person who attended the train-the-trainer workshop presented on the 23rd & 24th of June. If you have questions or comments for me, I may be contacted by telephone at (360) 236-3486 or via email at **frank.hayes@doh.wa.gov.**

The STD Focus

By Bonnie Nickle; DOH STD Educational Resource Coordinator

STD 101 FOR OUTREACH WORKERS

RESISTANCE AND MUTANTS MEAN EXTRA WORK FOR OUTREACH WORKERS

When the Department of Health staff looked at the reports clinicians fill out to show how many cases of a disease are present in each Washington State county, they noticed that while compliance with new medication recommendations for gonorrhea had improved, there was still a problem. That problem is mainly with private practice physicians. In March 2004 the CDC and Washington State recommended that drugs called fluoroquinolones (ciprofloxacin, levofloxacin, ofloxacin) no longer be used. This is because these once effective drugs now cause "resistance" for this infection. In other words, the bacteria that cause gonorrhea are no longer killed off at an efficient rate by those particular drugs. The bacteria evolve or mutate to resist death. A letter explaining this was sent to everyone who reported STDs in Washington State and different drugs were recommended.

When gonorrhea is treated with drugs that have become less effective, outreach workers have trouble. What happens is that your client with gonorrhea who has symptoms takes the incorrect drug. He may no longer have symptoms, think a cure has occurred and proceed to infect others because the fluoroquinolones may have been a little bit, but not completely, effective. Your client has no clue that he is still infectious. You cross him off your "to do" list, yet the disease spreads.

Men are more likely than women to have symptoms. About half of all women have no way of knowing they are infected. They feel, see, smell NOTHING. So what happens? The symptoms might not be there, but the inflammatory process is. An infection, silent or not, attracts white blood cells and other infection fighters to the site of that infection and this increases the risk for HIV transmission by two to five times. These cells just happen to be fast food for HIV and uptake is much more likely.

So, how do "they" know that these particular drugs are no longer working for gonorrhea? Public health lab staff and researchers set up a monitoring system and share information for many diseases. The one for gonorrhea is called the Gonococcal Isolate Surveillance Project (GISP). The people in the quinolone group within GISP are interested in QRNG (quinolone-resistant *N.gonorrhoeae).*

Disease monitoring should be planet-wide. There are not nearly enough sites and funding, but when scientists at Asian Pacific outposts began to report resistance they shared information with Hawaii and the other states with watch-dog sites. In King County, there was an emergence of fluoroquinolone resistance. From 1993 to 2002 resistance was less than two percent. By 2004 spread of resistance was more rapid, and reached 15 percent. Ciprofloxacin was the main problem with a failure rate of about 50% for some strains of gonorrhea, mainly in men who have sex with men.

Another problem for public health was that the makers of Cefixime, a first choice for treating gonorrhea, discontinued the drug. (There are more profitable patient groups than those needing STD treatment.) Lupin pharmaceuticals, an Indian company, was to have filled in the gap, but while this company has manufactured a pediatric liquid version of the drug, the

tablets needed for STD treatment have not been produced. A call to the company during the second week in October got a vague "perhaps by next year" response. So, at this time, the treatment recommendations are:

Ceftriaxone (Rocephin™) 125 mg IM in a single dose (a shot)

OR

Cefpodoxime (Vantin™) 400 mg orally in a single dose (tablets)

These drugs are called cephalosporins. If your client is allergic to these or similar drugs and he or she is treated with a fluoroquinolone, something called a "test of cure" must be done. For outreach workers, that means getting the client back to the clinic and lots of extra counseling to be sure that there is no risk behavior until a second test is negative, meaning no infection is present. Your help with coaching your clients to disclose risk and travel histories is crucial, especially for rural clients who party in cities.

More changes are coming in 2006 when it is expected that the CDC will issue new treatment guidelines for STDs. They will be posted on this web site. Hard copies will be provided as soon as possible.

Selected Readings

How to Read the References

Author(s), "Title," *Journal Name*, Date or Year; Volume (Number): Pages.

Key:

* Popular Reading

** Moderate Difficulty; Some Understanding Of Medical Terms

*** Medical Background Needed

**** Technical Reading.

HIV/AIDS

**** U.S. Preventive Services Task Force. "Screening for HIV: Recommendation Statement." *Annals of Internal Medicine.* July 5, 2005;143(1):32-37. In addition to this article, complete information on which this statement is based is posted at **http://preventiveservices.ahrq.gov.** There is a letter grade representing current consensus on the strength of each recommendation.

**** Smith D.M., Richman D.D., Little S.J. "HIV Superinfection." *Journal of Infectious Diseases.* July 5, 2005;192(3):438-444. Worldwide, 16 cases of HIV-1 superinfection in humans have been reported since 2002. This is a review of current understanding.

**** Mohlala B.K.F., Tucker T.J., Besser M.J. "Investigation of HIV in Amniotic Fluid from HIV-Infected Pregnant Women at Full Term." *Journal of Infectious Diseases.* August 1, 2005;192(3):488-491. In the absence of interventions and breast feeding, the in utero transmission rate of HIV is estimated to be 1-15%.

**** Guenthner P.C., Secor W.E., Dezzutti C.S. "*Trichomonas vaginalis*-Induced Epithelial Monolayer Disruption and Human Immunodeficiency Virus Type 1 (HIV-1) Replication: Implications for the Sexual Transmission of HIV-1." *Infection and Immunity.* July 2005;73(7):4155-4160. CDC article on STD-HIV interaction.

*** Osterberg L., Blaschke T. "Adherence to Medication." *New England Journal of Medicine.* August 1, 2005;353a(5):487-497. Review article.

*** Rosenow E.C. "Patients' Understanding of and Compliance With Medications: The Sixth Vital Sign?" *Mayo Clinic Proceedings.* August 2005;80(8):983-987. **http://www.mayoclinicproceedings.com/inside.asp?AID=980&UID=**. Costs, communication, patients' concerns, and recommendations related to a difficult problem.

**** Blankson J.N. "Primary HIV-1 Infection: To Treat or Not to Treat." *AIDS Reader.* 2005;15(5):245-251. Opinion and review. Note adherence issues and concerns about a 20-year time frame. This article is available at **http://www.medscape.com/viewarticle/510883_print.**

**** Harper S.A., Fukuda K., Uyeki T.M. and others. "Prevention and Control of Influenza." *Morbidity and Mortality Weekly Report.* July 29, 2005;54(RR08):1-40. Includes yet another review and recommendation for those with HIV infection.

**** Kannangara S., DeSimone J.A., Pomerantz R.J. "Attenuation of HIV-1 Infection by Other Microbial Agents." *Journal of Infectious Diseases.* September, 2005;292(6):1003-1009. Review and critical discussion.

** Halpern S.D. "HIV Testing Without Consent in Critically Ill Patients." *JAMA.* August 10, 2005;294(6):734-737. Pros and cons.

*** Casau N.C. "Perspective on HIV Infection and Aging: Emerging Research on the Horizon." *Clinical Infectious Diseases.* September 15, 2005; 41(6): 855-863. A greater prevalence of HIV+ individuals aged 50+ is projected. The author presents a review of current concerns for aging individuals on HAART and proposes future research. Includes extensive bibliography.

*** Kenagy G.P., Hsieh C.M. "The Risk Less Known: Female-to-Male Transgender Persons' Vulnerability to HIV Infection." *AIDS Care.* February 2005;17(2):195-207. Compared to MTFs, FTMs were significantly less likely to have used protection the last time they had sex and significantly more likely to have engaged in recent high risk sexual activity.

** Panlilio A.L., Cardo, D.M., Grohskopf L.A. and others. "Updated U.S., Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis." MMWR. September 30, 2005;54(RR-9):1-17.

*** The entire issue of the July 1, 2005 (41) supplement of *Clinical Infectious Diseases* is devoted to "Medical Management of HIV—Hepatitis C Virus Coinfection in Injection Drug Users."

STDs

** Holmes, K.K. Azithromycin versus Penicillin G Benzathine for Early Syphilis." *New England Journal of Medicine.* September 22;2005;353(12):1291-1293. Dr. Holmes states that given the lack of sustained effect of innovative uses of Azithromycin for managing outbreaks of syphilis in Vancouver and San Francisco, and the rapid emergence of macrolide-resistant *T. pallidum*, there seems little reason to change the forthcoming 2006 U.S. Sexually Transmitted Diseases (STD) Treatment Guidelines (still in draft at the CDC). This article speaks to the issue of PCN distribution, shortages and PCN allergy.

*** Spooner K., Barthel R.V., Robertson J. and others. "Azithromycin Might Not Protect Against *Treponema pallidum* Infection or Reactivation in HIV Type 1-Infected Patients." (Letter) *Clinical Infectious Diseases.* August 1,2005;41(3):420. Case notes with good references.

*** Morrow R.A., Brown Z.A. "Common Use of Inaccurate Antibody Assays to Identify Infection Status with Herpes Simples Virus Type 2." *American Journal of Obstetrics and Gynecology.* August 2005;193(2):361-362. These UW authors state that commercially available blood tests that were not glycoprotein G-based demonstrated high false positive (14% - 88%) rates. Many labs are using outdated tests and the FDA does not remove outdated or poorly performing tests from the market.

**** Burstein G.R., Snyder M.H., Conley D. and others. "Chlamydia Screening in a Health Plan Before and After a National Performance Measure Introduction." *Obstetrics and Gynecology.* August 2,2005;106(2):327-334. With implementation of CT testing as a performance measure for HEDIS (Health Plan Employer Data and Information Set) in an OB department, the proportion tested during visits for routine Pap tests increased.

*** Kent C., Chaw J.K., Wong W. and others. "Prevalence of Rectal, Urethral and Pharyngeal Chlamydia and Gonorrhea Detected in 2 Clinical Settings among Men Who Have Sex with Men: San Francisco, California, 2003." *Clinical Infectious Diseases.* July 1, 2005;41(1):67-74. Tests: ProbTec (NAATs) GC-culture, confirmed with FA.

** Tebb K.P., Pantell R.H, Wibbelsman C.J. and others. "Screening Sexually Active Adolescents for *Chlamydia trachomatis:* What About the Boys*?"American Journal of Public Health.* October 2005;95(10):1806-1810.

*** Tapsall J.W. "Antibiotic Resistance in *Neisseria gonorrhoeae." Clinical Infectious Diseases.* August 15, 2005;41(Supplement 4): S263-S268.

*** Handsfield H.H., Waldo A.B., Brown Z.A. "Neonatal Herpes Should Be a Reportable Disease." *Sexually Transmitted Diseases.* September 2005;32((9):521-525. Neonatal herpes is a reportable disease in Washington state. These adult and pediatric STD experts argue for national surveillance now that the potential for prevention has been upgraded with therapeutic and diagnostic advances.

*** Ford C.A., Pence B.W., Miller W.C. and others. "Predicting Adolescents' Longitudinal Risk for Sexually Transmitted Infection." *Archives of Pediatrics and Adolescent Medicine.* July 2005;159(7):657-664. In a six year follow-up female but not male adolescents who perceived that their parents more strongly disapproved of their having sex during adolescence were less likely to have STIs 6 years later as were those with higher grades. Religion, parochial school attendance and virginity pledges did not predict STI status 6 years later.

**** Price G.A., Russell M.W., Cornelissen C. "Intranasal Administration of Recombinant *Neisseria gonorrhoeae* Transferrin Binding Proteins A and B Conjugated to the Cholera Toxin B Subunit Induces Systemic and Vaginal Antibodies in Mice." *Infection and Immunity.* July 2005 Vol 73(7):3945-3953. This very preliminary lab animal work on a vaccine for gonorrhea was publicized by popular press reports.

*** Kellgog N. and the Committee on Child Abuse and Neglect, American Academy of Pediatrics. "Guidelines for the Evaluation of Sexual Abuse of Children" *Pediatrics.* August 2005;116(2):506-512. Update of the 1999 guidelines. Be sure to print out tables such as #2 which includes lab findings and levels of concern. **http://pediatrics.aappublications.org/cgi/content/ full/116/2/506.**

**** Söderlund-Strand A., Rymark P., Andersson P. and others. "Comparison between the Hybrid Capture II Test and a PCR-Based Human Papillomavirus Detection Method for diagnosis and Posttreatment Follow-Up of Cervical Intraepithelial Neoplasia." *Journal of Clinical Microbiology.* July 2005;43(7):3260-3266. At 4 and 6 months follow-up on 177 patients, sensitivities for CIN III were 100% for both methods and 80% for CIN II+. Specificities for CIN II+ were 83.5% for PCR and 85.4% for HCII.

**** Cuscheri K.C., Cubie H.A., Whitley M.W. and others. "Persistent High Risk HPV Infection Associated with Development of Cervical Neoplasia in a Prospective Population Study." *Journal of Clinical Pathology.* September 2005;58(9);946-950. The authors argue that type-specific monitoring by genotyping can identify those at increased risk of cervical neoplasia more accurately than a single or repeated presence/absence HPV test and call for a large scale cost-benefit analysis of this proposition.

FAMILY PLANNING

*** Klein J.D. and the Committee on Adolescence. "Adolescent Pregnancy: Current Issues and Trends." *Pediatrics.* July2005;116(1):281-286. This article updates the 1998 sex education policy statement of the American Academy of Pediatrics. Ensuring knowledge of and access to contraception. Emergency contraception (EC) is included in the policy.

** "QuickStats: Percentage of Never-Married Teens Aged 15—19 Years Who Reported Ever Having Sexual Intercourse, by Sex and by Age Group --- United States, 1995 and 2002." *MMWR.* August 5, 2005;54(30:751. Clear graphic of reported decrease.

**** Santen R.J., Mansel R. "Benign Breast Disorders." *New England Journal of Medicine.* July 21, 2005;353(3):275-285. Review article – includes algorithm and charts, classifications, pain, discharge, lumps, abnormalities associated with cancer, treatments, and prevention.

*** *The Guttmacher Institute.* "2004 Family Planning Annual Report." 78 pages. **http://www.guttmacher.org/pubs/FPAR2004.pdf.** Title X clinics served 5.1 million clients in 2004 – an increase of 1%. Men accounted for about one-third of the increase.

*** Sieverding J.A., Adles N., Witt S. "The Influence of Parental Monitoring on Adolescent Sexual Initiation." *Archives*

of Pediatrics and Adolescent Medicine. August 8, 2005;159(8):724-729. Preliminary work on designing interventions that delay the onset of sexual intercourse.

*** Kaestie C.E., Halpern C.T. "Sexual Activity Among Adolescents in Romantic Relationships with Friends, Acquaintances or Strangers." *Archives of Pediatrics and Adolescent Medicine.* September 2005;159(9):849-853.

TB

**** McElroy P.D., Ijaz K., Lambert L.A. and others. "National Survey to Measure Rates of Liver Injury, Hospitalization, and Death Associated with Rifampin and Pyrazinamide for Latent Tuberculosis Infection." *Clinical Infectious Diseases.* October 15, 2005;41(8):1125-1133. CDC recommends that rifampin-pyrazinamide generally should not be used for treatment of latent TB infection.

**** Breen R., Smith C., Cropley I.A. and others. "Does Immune Reconstitution Syndrome Promote Active Tuberculosis in Patients Receiving Highly Active Antiretroviral Therapy?" *AIDS.* July 22,2005;19(11):1201-1206. The need for more research and careful consideration of therapy for those with TB.

*** Wallis R.S. "Reconsidering Adjuvant Immunotherapy for Tuberculosis." *Clinical Infectious Diseases.* July 15, 2005;41(2):201-208. Exploration of hypotheses on the targeted disruption of granulomas formed as a host response to contain TB.

**** "Multidrug-Resistant Tuberculosis in Hmong Refugees Resettling from Thailand into the United States, 2004-2005." *MMWR.* August 5, 2005;54(30):741-744. The standard pre-migration algorithm was revised in May 2004 to add additional requirements.

** MacNeil J.R., Lobato M.N., Moore M. "An Unanswered Health Disparity: Tuberculosis Among Correctional Inmates, 1993-2003." *American Journal of Public Health.* October 2005;95(10):1800-1805.

**** Moon J.W., Chang Y.S., Kim S.K. and others. "The Clinical Utility of Polymerase Chain Reaction for the Diagnosis of Pleural Tuberculosis." *Clinical Infectious Diseases.* September 1, 2005;41(5):660-666.

**** Hazbón M.H., Bobadilla del Valle M., Guerrero M.I. and others. "Role of *embB* Codon 306 Mutations in *Mycobacterium tuberculosis* Revisited: a Novel Association with Broad Drug Resistance and IS6110 Clustering Rather than Ethambutol Resistance." *Antimicrobial Agents and Chemotherapy.* September 2005;49(9):3794-3802. The authors state that embB306 mutations do not cause classical ethambutol resistance but may predispose TB isolates to the development of resistance to increasing numbers of antibiotics and may increase the ability of drug-resistant isolates to be transmitted between subjects.

**** Doherty M.T., Andersen P. "Vaccines for Tuberculosis: Novel Concepts and Recent Progress." *Clinical Microbiology Reviews.* October 2005;18(4):687-702. How TB subverts or survives immune response, why current vaccine (BCG) is only partially successful, and descriptions of potential candidates to replace or supplement BCG.

** Mackowisk P.A., Blos V.T., Aguilar M., Buikstra J.E. On the Origin of American Tuberculosis." *Clinical Infectious Diseases.* August 15, 2005;41(4):515-518. The authors state that after more than a century of debate, it is now firmly established that TB existed in the Americas before the arrival of Columbus. What is not known is how or when, exactly, it arrived and whether the pre-Columbian infection was caused by *Mycobacterium tuberculosis* or *Mycobacterium bovis.* Includes discussion of comparison photographs of a Mayan terra cotta figurine and a contemporary picture of Pott disease, information on mummies and PCR technologies, speculations and specifics. Great stuff for students.

Hepatitis

*** http://www.nature.com/nature/journal/v436/n7053/index.html *Nature.* August 18, 2005; 436:929-978. The scientific journal *Nature* has granted free access to a series of articles on hepatitis C that includes new

information on the mechanism of action of interferon and ribavirin, adaptive immune responses, viral-host interactions, transplants, and prospects for a (partly effective) vaccine. Scroll way down the contents page to get to the articles.

**** Layden-Almer J.E., Kulken C. Riberio R.M. "Hepatitis C Virus Genotype 1a NS5A Pretreatment Sequence Variations and Viral Kinetics in African American and White Patients." *Journal of Infectious Diseases.* September 15, 2005;192(6):1078-1087. Responders to INF treatment tended to have more mutations in the V3 region.

**** Lindenbach B.D., Evans M.J., Syder A.J. and others. "Complete Replication of Hepatitis C Virus." *Science.* July 22, 2005;309(5734):523-525.

** Macalino G.E., Dhawan D., Rich J.D. "A Missed Opportunity: Hepatitis C Screening of Prisoners." *American Journal of Public Health.* October 2005;95(10):1739-1740. Of male inmates who were hepatitis C positive in this Rhode Island prison population, 66% did not report injection drug use. Self reported risk-based testing underestimates the hepatitis C virus prevalence in correctional settings and limits the opportunity to diagnose and prevent hepatitis C infection.

**** Lee W.M., Polson J.E., Carney D.S. "Reemergence of Hepatitis C Virus after 8.5 Years in a Patient with Hypogammaglobulinemia: Evidence for an Occult Viral Reservoir." *Journal of Infectious Diseases.* September 2005;192(6):1088-1092. Apparent resolution, relapse, then clearance after INF therapy, then apparent relapse and clearance with corticosteroid therapy of identical viral type.

**** Jopling C.L., Yi M.K., Lancaster A.M. and others. "Modulation of Hepatitis C Virus RNA Abundance by a Liver-Specific MicroRNA." *Science.* September 2, 2005;309(5740):1577-1581.

*** Gilbert L.K., Bulger J. Scanlon K. and others. "Integrating Hepatitis B Prevention Into Sexually Transmitted Disease Services: U.S. Sexually Transmitted Disease Program and Clinic Trends ---1997 and 2001." *Sexually Transmitted Diseases.* June 2005;32(6):346-350. Lack of funding, lack of money for vaccine, tracking mechanisms and staff to ensure return to clinic for completion of vaccine series were among the barriers listed.

**** Schiff E.R., Fried M.W., Jacobson I.M. and others. "Chronic Hepatitis B: Refining Management Approaches and Addressing the Issues." Medscape CME, 85 pages, assumes knowledge of basic hepatology **http://www.medscape.com/viewprogram/4407_pnt.** Cornell, UNC Chapel Hill, and other authors disclose grant and research support on page 84.

** Suk-Fong A. "The Maze of Treatments for Hepatitis B." *New England Journal of Medicine.* (Editorial) June 30, 2005;352(26):2743-2746. Reviews the five approved therapies for chronic hepatitis B and includes a table noting efficacy of the various treatments.

** Wasley A., Sammandari T., Bell B.P. "Incidence of Hepatitis A in the United States in the Era of Vaccination." *JAMA.* July 13, 2005;294(2):194-201. Rates have declined to historic lows since the implementation of vaccination.

* Brody J. "Stalking a Cancer That's Silent and Deadly." *New York Times.* October 11, 2005. Updated hepatitis B and C information in an easy-to-read format.

Substance abuse

** McKnight C.A., Des Jarlais D.C., Perlis T. and others. "Update: Syring Exchange Programs --- United States, 2002. *Morbidity and Mortality Weekly Report.* July 15, 2005;54(27):673-676. For the first time in 8 years, the number of SEPs , the number of localities with SEPS, and public financing for SEPS decreased nationwide. The number of syringes exchanged increased. SEPS can help prevent bloodborne pathogen transmission, help with safe disposal of used syringes, provide referrals to health services for testing and treatment and provide referrals for substance abuse treatment.

** Zernike K. "A Drug Scourge Creates Its Own Form of Orphan." *New York Times*. July 11, 2005, page 1. Outlines Public health and child welfare problems in rural areas overwhelmed with methamphetamine use and manufacture.

*** Snead O.C., Gibson M. "γ-Hydroxybutyric Acid. *New England Journal of Medicine*. June 30, 2005;352(26):27212732. Review article on GHB, a party, club, "rave" and " date rape" drug. Street names include G, liquid ecstasy, grievous body harm, Georgia home boy, liquid X, soap, easy lay, salty water, scoop, cherry meth, and nitro.

**** Collins E.D., Kleber H.D., Whittington R.A. "Anesthesia-Associated vs Buprenorphine-or Clonidine-Assisted Heroin Detoxification and Naltrexone Induction: A Randomized Trial." *JAMA*. August 24/31;294(8):903-913. These data do not support the use of general anesthesia for heroin detoxification

** Hoffman R.S., Nelson L.S., Chan G.M. and others. "Atypical Reactions Associated With Heroin Use --- Five States, January – April 2005." *MMWR*. August 19, 2005;54(32):793-796. Clenbuterol, a b_2 adrenergic receptor agonist with rapid onset and long duration is approved for limited veterinary use. It is used illicitly as an anabolic steroid.

Other Health Resources

In case of earthquake or other emergency, advice from the FDA Listserve: Some HIV-infected patients may have interrupted their antiretroviral therapy and other medications due to the recent hurricane disasters. The following link provides some guidance to the general practitioners attending to the medical needs of displaced HIV-infected adult or pediatric patients who have not yet secured HIV care in the local area. Management of antiretroviral therapy is complex and should best be done with the assistance of specialized clinicians. To see the recommendations go to: **http://aidsinfo.nih.gov/guidelines/disaster/2EssentialsforManagingHIV1ap.pdf** Medical consultation may also be available at specific local or regional HIV clinics or via the 24-hour NIH Medical Consultation Services at 1-866-887-2842 or the National HIV Telephone Consultation Service: at 1-800-933-3413.

http://www.osha.gov/SLTC/bloodbornepathogens/index.html is the gateway page for **OSHA's bloodborne pathogen guidelines**. The new format is easy to navigate with direct links for post-exposure prophylaxis, hazard recognition, and "possible solutions." The **Infectious Disease in Corrections Report (IDCR)** for August includes information on gloves, and an algorithm for occupational exposure to bloodborne pathogens at **www.IDCRonline.org.**

The **Kaiser Family Foundation** has updated its **fact sheets** on global HIV/AIDS, HIV/AIDS in the US, Medicaid eligibility and Medicare eligibility. All four updated fact sheets are available online at **http://www.kff.org/content/factsheets.cfm**.

"Minority Populations and Health: An Introduction to Health Disparities in the United States." by Thomas A. LaVeist, 348 pages, $65.00, ISNN 0-7879-6413-1, San Francisco, California, Jossey-Bass publishers, 2005. Health status disparities, health care disparities, and interventions.

http://www.phppo.cdc.gov/phtn/default.asp is the address for **CDC's public health training network**. Check out the scheduled web casts and the material in the archives including the new HIV screening guidelines and clinical information on HPV. Some of the courses include continuing education credits.

The "**Revised Recommendations for HIV Screening** of Adults, Adolescents, and Pregnant Women in Health Care Settings" can be accessed by those with Internet and RealPlayer® capability at **http://www.phppo.cdc.gov/phtn**. Videotapes and video CD-ROMs of the November 17, 2005 CDC broadcast can be ordered by telephone, 800-458-5231.

"**Real Health: The Guide to Black Wellness**" is a magazine by the editors of POZ; the HIV/AIDS quarterly publication has a wide variety of health and mental health articles of interest to those who are and are not HIV+.

Check out **http://www.jmhg.org/english/content_engl.htm** for a look at the contents page of a new journal, ***The Journal of Men's Health and Gender***.

The National Cancer Institute's 251-page "Pink Book," **MAKING HEALTH COMMUNICATION PROGRAMS WORK**, has been revised and is available at no charge. Call 1-800-422-6237 for your copy. This is excellent material for health education students, those with limited funding, or those new to the demands of planning, assessment, research, change models, and outcome measures.

At **http://www.metrokc.gov/health/famplan/FLASH** you can check out the updated chapters for the **F.L.A.S.H. curriculum**.

http://www.cdc.gov/nchs/ provides a link to the National Center for **Health Statistics** and **http://www.teenpregnancy.org/** to the National **Campaign to Prevent Teen Pregnancy** for information on the final data from 2003 on the 3% decrease in teen pregnancy and 3% increase in births to single women of all ages. The rate for teens has dropped by one-third since reaching a record high in 1991.

"Increased risk of incident HIV during pregnancy in Rakai, Uganda: a prospective study," *Lancet*: Ronald Gray of the Johns Hopkins Bloomberg School of Public Health and colleagues compared HIV incidence rates among sexually active pregnant and lactating women in Uganda to incidence among sexually active nonpregnant and nonlactating women. **The researchers found that the risk of HIV infection during pregnancy increases**. Hormonal changes affecting the genital tract or immune system, not changes in sexual behavior, likely are the cause of the increased risk, according to researchers. The researchers recommend targeted HIV prevention for pregnant women (Gray et al., *Lancet*, 10/1).

Public Health Seattle and King County HIV/AIDS program has developed 2 new booklets for people who want to help a loved one involved in **problematic drug or alcohol use**. The booklets, entitled "When Your *Friend* Has a Drug or Alcohol Problem" and "When Your *Partner* has a Drug or Alcohol Problem", are practical advice guides for gay and bi men on how to help a friend or partner deal with substance use. Special topics include:

- Understanding addiction
- Stages of addiction in relationships
- What helps and what doesn't
- Taking care of yourself
- FAQS about treatment
- How to support recovery

Go to **http://www.metrokc.gov/health/apu/menuhr.htm.** For those interested in obtaining free print copies, please contact **susan.kingston@metrokc.gov** or call 206-205-6105.

TABLE 1. WASHINGTON STATE HIV[1] AND AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, AS OF 09/30/2005

	TOTAL CASES (& CASE FATALITY RATE[2]) DIAGNOSED DURING INTERVAL[3]					DEATHS OCCURRING DURING INTERVAL[4]		CASES PRESUMED LIVING DIAGNOSED DURING INTERVAL[3]		
	HIV[1]		AIDS		**HIV/AIDS**	*HIV[1]*	AIDS	*HIV[1]*	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**Total**	*No.*	No.	*No.*	No.	**Total**
1982	2	*(0%)*	1	(100%)	**3**	*0*	0	2	0	**2**
1983	5	*(20%)*	20	(100%)	**25**	*0*	7	4	0	**4**
1984	7	*(0%)*	79	(97%)	**86**	*0*	31	7	2	**9**
1985	68	*(10%)*	132	(98%)	**200**	*0*	81	61	3	**64**
1986	59	*(15%)*	245	(98%)	**304**	*0*	126	50	5	**55**
1987	73	*(16%)*	369	(96%)	**442**	2	188	61	15	**76**
1988	83	*(18%)*	493	(94%)	**576**	6	236	68	29	**97**
1989	118	*(16%)*	612	(92%)	**730**	8	309	99	49	**148**
1990	138	*(20%)*	733	(91%)	**871**	6	371	111	63	**174**
1991	152	*(12%)*	835	(88%)	**987**	4	461	134	100	**234**
1992	137	*(11%)*	897	(79%)	**1,034**	7	515	122	189	**311**
1993	121	*(10%)*	943	(71%)	**1,064**	12	617	109	277	**386**
1994	171	*(7%)*	852	(59%)	**1,023**	10	676	159	351	**510**
1995	183	*(5%)*	754	(41%)	**937**	6	665	173	444	**617**
1996	226	*(5%)*	662	(28%)	**888**	8	495	214	475	**689**
1997	226	*(5%)*	512	(22%)	**738**	10	226	214	400	**614**
1998	221	*(2%)*	384	(24%)	**605**	6	167	216	290	**506**
1999	277	*(2%)*	351	(24%)	**628**	7	137	271	268	**539**
2000	339	*(3%)*	430	(20%)	**769**	34	165	328	345	**673**
2001	313	*(1%)*	388	(15%)	**701**	24	153	310	329	**639**
2002	310	*(2%)*	412	(12%)	**722**	23	157	304	363	**667**
2003	327	*(1%)*	419	(10%)	**746**	28	184	325	376	**701**
2004[5]	339	*(0%)*	398	(6%)	**737**	9	153	339	374	**713**
2005 YTD[5]	223	*(1%)*	242	(4%)	**465**	6	64	221	232	**453**
TOTAL	*4,118*	*(5%)*	11,163	(55%)	**15,281**	*216*	6,184	*3,902*	4,979	**8,881**

TABLE 2. WASHINGTON STATE HIV[1] AND AIDS CASES, GENDER BY AGE AT DIAGNOSIS

	HIV[1]						AIDS					
	Male		*Female*		*Total*		Male		Female		Total	
	No.	*(%)*	*No.*	*(%)*	*No.*	*(%)*	No.	(%)	No.	(%)	No.	(%)
Under 13	17	*(0%)*	21	*(1%)*	*38*	*(1%)*	15	(0%)	17	(0%)	32	(0%)
13-19	61	*(1%)*	39	*(1%)*	*100*	*(2%)*	31	(0%)	12	(0%)	43	(0%)
20-29	1139	*(28%)*	221	*(5%)*	*1,360*	*(33%)*	1647	(15%)	230	(2%)	1,877	(17%)
30-39	1459	*(35%)*	176	*(4%)*	*1,635*	*(40%)*	4692	(42%)	382	(3%)	5,074	(45%)
40-49	678	*(16%)*	96	*(2%)*	*774*	*(19%)*	2722	(24%)	224	(2%)	2,946	(26%)
50-59	155	*(4%)*	28	*(1%)*	*183*	*(4%)*	814	(7%)	94	(1%)	908	(8%)
60+	24	*(1%)*	4	*(0%)*	*28*	*(1%)*	248	(2%)	35	(0%)	283	(3%)
TOTAL	*3,533*	*(86%)*	*585*	*(14%)*	*4,118*	*(100%)*	10,169	(91%)	994	(9%)	11,163	(100%)

1 Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

2 Case fatality rate is the proportion of HIV or AIDS patients diagnosed during interval who are known to have died at some time since diagnosis.

3 Year of diagnosis reflects the time at which HIV infection or AIDS was diagnosed by a health care provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

4 Includes deaths among HIV or AIDS patients diagnosed during that interval or any preceding interval.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

IDRH Assessment Unit, P.O. Box 47838, Olympia, WA 98504-7838; (360) 236-3455.

TABLE 3. WASHINGTON STATE HIV[1] CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 09/30/2005

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	2659	(76%)	290	(51%)	14	(36%)	2963	(72%)
Black, not Hispanic	411	(12%)	177	(31%)	15	(38%)	603	(15%)
Hispanic (All Races)	278	(8%)	50	(9%)	6	(15%)	334	(8%)
Asian/Pacific Islander	2	(0%)	4	(1%)	0	(0%)	6	(0%)
Asian	84	(2%)	11	(2%)	4	(10%)	99	(2%)
Hawaiian/Pacific Islander	5	(0%)	1	(0%)	0	(0%)	6	(0%)
Native American/Alaskan	35	(1%)	27	(5%)	0	(0%)	62	(2%)
Multi-race	14	(0%)	1	(0%)	0	(0%)	15	(0%)
Unknown	27	(1%)	3	(1%)	0	(0%)	30	(1%)
Total	3,515	(100%)	564	(100%)	39	(100%)	4,118	(100%)
Exposure Category								
Male/male sex (MSM)	2573	(73%)	0	(0%)	0	(0%)	2573	(62%)
Injecting Drug Use (IDU)	246	(7%)	141	(25%)	0	(0%)	387	(9%)
MSM and IDU	346	(10%)	0	(0%)	0	(0%)	346	(8%)
Transfusion/Transplant	9	(0%)	10	(2%)	0	(0%)	19	(0%)
Hemophilia	12	(0%)	1	(0%)	1	(3%)	14	(0%)
Heterosexual Contact[6]	125	(4%)	278	(49%)	0	(0%)	403	(10%)
Mother at Risk for HIV	0	(0%)	0	(0%)	35	(90%)	35	(1%)
No Identified Risk[7]/Other	204	(6%)	134	(24%)	3	(8%)	341	(8%)
Total	3,515	(100%)	564	(100%)	39	(100%)	4,118	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 4. WASHINGTON STATE AIDS CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 09/30/2005

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	8079	(80%)	534	(55%)	15	(47%)	8628	(77%)
Black, not Hispanic	970	(10%)	266	(27%)	10	(31%)	1246	(11%)
Hispanic (All Races)	736	(7%)	86	(9%)	4	(13%)	826	(7%)
Asian/Pacific Islander	31	(0%)	13	(1%)	1	(3%)	45	(0%)
Asian	121	(1%)	15	(2%)	0	(0%)	136	(1%)
Hawaiian/Pacific Islander	21	(0%)	7	(1%)	0	(0%)	28	(0%)
Native American/Alaskan	157	(2%)	49	(5%)	1	(3%)	207	(2%)
Multi-race	29	(0%)	5	(1%)	1	(3%)	35	(0%)
Unknown	10	(0%)	2	(0%)	0	(0%)	12	(0%)
Total	10,154	(100%)	977	(100%)	32	(100%)	11,163	(100%)
Exposure Category								
Male/male sex (MSM)	7402	(73%)	N/A	( )	0	(0%)	7402	(66%)
Injecting Drug Use (IDU)	731	(7%)	284	(29%)	0	(0%)	1015	(9%)
MSM and IDU	1108	(11%)	N/A	( )	0	(0%)	1108	(10%)
Transfusion/Transplant	72	(1%)	51	(5%)	0	(0%)	123	(1%)
Hemophilia	83	(1%)	4	(0%)	4	(13%)	91	(1%)
Heterosexual Contact[6]	291	(3%)	486	(50%)	0	(0%)	777	(7%)
Mother at Risk for HIV	0	(0%)	0	(0%)	28	(88%)	28	(0%)
No Identified Risk[7]/Other	467	(5%)	152	(16%)	0	(0%)	619	(6%)
Total	10,154	(100%)	977	(100%)	32	(100%)	11,163	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

* For explanation of revised AIDS total, see technical notes

TABLE 5. WA STATE HIV[1] & AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, BY COUNTY OF RESIDENCE[8] AT DIAGNOSIS, AS OF 09/30/2005

	CASES DIAGNOSED					DEATHS				PRESUMED LIVING				
	HIV[1]	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**	*HIV[1]*	*HIV[1]*	AIDS	AIDS	*HIV[1]*	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**TOTAL**	*No.*	*(%)*	No.	(%)	*No.*	*(%)*	No.	(%)	**TOTAL**
REGION 1	*169*	*(4.1%)*	620	(5.6%)	**789**	*14*	*(6.5%)*	340	(5.5%)	*155*	*(4.0%)*	280	(5.6%)	**435**
ADAMS CO.	*1*	*(0.0%)*	5	(0.0%)	**6**	*0*	*(0.0%)*	1	(0.0%)	*1*	*(0.0%)*	4	(0.1%)	**5**
ASOTIN CO.	*4*	*(0.1%)*	15	(0.1%)	**19**	*1*	*(0.5%)*	6	(0.1%)	*3*	*(0.1%)*	9	(0.2%)	**12**
COLUMBIA CO.	*1*	*(0.0%)*	4	(0.0%)	**5**	*0*	*(0.0%)*	3	(0.0%)	*1*	*(0.0%)*	1	(0.0%)	**2**
FERRY CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	6	(0.1%)	*0*	*(0.0%)*	1	(0.0%)	**1**
GARFIELD CO.	*1*	*(0.0%)*	0	(0.0%)	**1**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	0	(0.0%)	**1**
LINCOLN CO.	*0*	*(0.0%)*	4	(0.0%)	**4**	*0*	*(0.0%)*	2	(0.0%)	*0*	*(0.0%)*	2	(0.0%)	**2**
OKANOGAN CO.	*7*	*(0.2%)*	26	(0.2%)	**33**	*0*	*(0.0%)*	9	(0.1%)	*7*	*(0.2%)*	17	(0.3%)	**24**
PEND OREILLE CO.	*1*	*(0.0%)*	8	(0.1%)	**9**	*0*	*(0.0%)*	5	(0.1%)	*1*	*(0.0%)*	3	(0.1%)	**4**
SPOKANE CO.	*140*	*(3.4%)*	468	(4.2%)	**608**	*12*	*(5.6%)*	267	(4.3%)	*128*	*(3.3%)*	201	(4.0%)	**329**
STEVENS CO.	*5*	*(0.1%)*	19	(0.2%)	**24**	*0*	*(0.0%)*	10	(0.2%)	*5*	*(0.1%)*	9	(0.2%)	**14**
WALLA WALLA CO.	*8*	*(0.2%)*	52	(0.5%)	**60**	*1*	*(0.5%)*	27	(0.4%)	*7*	*(0.2%)*	25	(0.5%)	**32**
WHITMAN CO.	*1*	*(0.0%)*	12	(0.1%)	**13**	*0*	*(0.0%)*	4	(0.1%)	*1*	*(0.0%)*	8	(0.2%)	**9**
REGION 2	*136*	*(3.3%)*	374	(3.4%)	**510**	*9*	*(4.2%)*	184	(3.0%)	*127*	*(3.3%)*	190	(3.8%)	**317**
BENTON CO.	*25*	*(0.6%)*	76	(0.7%)	**101**	*1*	*(0.5%)*	37	(0.6%)	*24*	*(0.6%)*	39	(0.8%)	**63**
CHELAN CO.	*18*	*(0.4%)*	36	(0.3%)	**54**	*2*	*(0.9%)*	22	(0.4%)	*16*	*(0.4%)*	14	(0.3%)	**30**
DOUGLAS CO.	*2*	*(0.0%)*	2	(0.0%)	**4**	*0*	*(0.0%)*	2	(0.0%)	*2*	*(0.1%)*	0	(0.0%)	**2**
FRANKLIN CO.	*20*	*(0.5%)*	47	(0.4%)	**67**	*1*	*(0.5%)*	14	(0.2%)	*19*	*(0.5%)*	33	(0.7%)	**52**
GRANT CO.	*10*	*(0.2%)*	30	(0.3%)	**40**	*1*	*(0.5%)*	19	(0.3%)	*9*	*(0.2%)*	11	(0.2%)	**20**
KITTITAS CO.	*4*	*(0.1%)*	15	(0.1%)	**19**	*0*	*(0.0%)*	8	(0.1%)	*4*	*(0.1%)*	7	(0.1%)	**11**
KLICKITAT CO.	*4*	*(0.1%)*	9	(0.1%)	**13**	*0*	*(0.0%)*	6	(0.1%)	*4*	*(0.1%)*	3	(0.1%)	**7**
YAKIMA CO.	*53*	*(1.3%)*	159	(1.4%)	**212**	*4*	*(1.9%)*	76	(1.2%)	*49*	*(1.3%)*	83	(1.7%)	**132**
REGION 3	*314*	*(7.6%)*	896	(8.0%)	**1,210**	*24*	*(11.1%)*	464	(7.5%)	*290*	*(7.4%)*	432	(8.7%)	**722**
ISLAND CO.	*15*	*(0.4%)*	58	(0.5%)	**73**	*1*	*(0.5%)*	33	(0.5%)	*14*	*(0.4%)*	25	(0.5%)	**39**
SAN JUAN CO.	*6*	*(0.1%)*	18	(0.2%)	**24**	*1*	*(0.5%)*	10	(0.2%)	*5*	*(0.1%)*	8	(0.2%)	**13**
SKAGIT CO.	*26*	*(0.6%)*	57	(0.5%)	**83**	*4*	*(1.9%)*	33	(0.5%)	*22*	*(0.6%)*	24	(0.5%)	**46**
SNOHOMISH CO.	*217*	*(5.3%)*	615	(5.5%)	**832**	*15*	*(6.9%)*	309	(5.0%)	*202*	*(5.2%)*	306	(6.1%)	**508**
WHATCOM CO.	*50*	*(1.2%)*	148	(1.3%)	**198**	*3*	*(1.4%)*	79	(1.3%)	*47*	*(1.2%)*	69	(1.4%)	**116**
REGION 5	*458*	*(11.1%)*	1,177	(10.5%)	**1,635**	*30*	*(13.9%)*	661	(10.7%)	*428*	*(11.0%)*	516	(10.4%)	**944**
KITSAP CO.	*77*	*(1.9%)*	199	(1.8%)	**276**	*2*	*(0.9%)*	115	(1.9%)	*75*	*(1.9%)*	84	(1.7%)	**159**
PIERCE CO.	*381*	*(9.3%)*	978	(8.8%)	**1,359**	*28*	*(13.0%)*	546	(8.8%)	*353*	*(9.0%)*	432	(8.7%)	**785**
REGION 6	*328*	*(8.0%)*	924	(8.3%)	**1,252**	*14*	*(6.5%)*	474	(7.7%)	*314*	*(8.0%)*	450	(9.0%)	**764**
CLALLAM CO.	*20*	*(0.5%)*	52	(0.5%)	**72**	*2*	*(0.9%)*	28	(0.5%)	*18*	*(0.5%)*	24	(0.5%)	**42**
CLARK CO.	*145*	*(3.5%)*	404	(3.6%)	**549**	*3*	*(1.4%)*	209	(3.4%)	*142*	*(3.6%)*	195	(3.9%)	**337**
COWLITZ CO.	*35*	*(0.8%)*	90	(0.8%)	**125**	*1*	*(0.5%)*	51	(0.8%)	*34*	*(0.9%)*	39	(0.8%)	**73**
GRAYS HARBOR CO.	*15*	*(0.4%)*	51	(0.5%)	**66**	*1*	*(0.5%)*	32	(0.5%)	*14*	*(0.4%)*	19	(0.4%)	**33**
JEFFERSON CO.	*9*	*(0.2%)*	22	(0.2%)	**31**	*3*	*(1.4%)*	15	(0.2%)	*6*	*(0.2%)*	7	(0.1%)	**13**
LEWIS CO.	*8*	*(0.2%)*	40	(0.4%)	**48**	*1*	*(0.5%)*	25	(0.4%)	*7*	*(0.2%)*	15	(0.3%)	**22**
MASON CO.	*20*	*(0.5%)*	73	(0.7%)	**93**	*0*	*(0.0%)*	24	(0.4%)	*20*	*(0.5%)*	49	(1.0%)	**69**
PACIFIC CO.	*9*	*(0.2%)*	16	(0.1%)	**25**	*1*	*(0.5%)*	10	(0.2%)	*8*	*(0.2%)*	6	(0.1%)	**14**
SKAMANIA CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	5	(0.1%)	*0*	*(0.0%)*	2	(0.0%)	**2**
THURSTON CO.	*66*	*(1.6%)*	167	(1.5%)	**233**	*2*	*(0.9%)*	75	(1.2%)	*64*	*(1.6%)*	92	(1.8%)	**156**
WAHKIAKUM CO.	*1*	*(0.0%)*	2	(0.0%)	**3**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	2	(0.0%)	**3**
SUBTOTAL	*1,405*	*(34.1%)*	3,991	(35.8%)	**5,396**	*91*	*(42.1%)*	2,123	(34.3%)	*1,314*	*(33.7%)*	1,868	(37.5%)	**3,182**
REGION 4 (KING CO)	*2,713*	*(65.9%)*	7,172	(64.2%)	**9,885**	*125*	*(57.9%)*	4,061	(65.7%)	*2,588*	*(66.3%)*	3,111	(62.5%)	**5,699**
STATE TOTAL	*4,118*	*(100%)*	11,163	(100%)	**15,281**	*216*	*(100%)*	6,184	(100%)	*3,902*	*(100%)*	4,979	(100%)	**8,881**

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

8. County of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing..

TABLE 6. WASHINGTON STATE HIV[1] CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 09/30/2005

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2001		2002		2003		2004[5]		2005 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	382	(92%)	1,147	(85%)	2,004	(85%)	3,533	(86%)	272	(87%)	263	(85%)	278	(85%)	290	(86%)	192	(86%)
Female	33	(8%)	207	(15%)	345	(15%)	585	(14%)	41	(13%)	47	(15%)	49	(15%)	49	(14%)	31	(14%)
Total	415	(100%)	1,354	(100%)	2,349	(100%	4,118	(100%	313	(100%	310	(100%	327	(100%)	339	(100%)	223	(100%
Race/Ethnicity[10]																		
White, not Hispanic	354	(85%)	1,047	(77%)	1,562	(66%)	2,963	(72%)	215	(69%)	200	(65%)	216	(66%)	209	(62%)	139	(62%)
Black, not Hispanic	40	(10%)	161	(12%)	402	(17%)	603	(15%)	46	(15%)	67	(22%)	61	(19%)	65	(19%)	35	(16%)
Hispanic (All Races)	10	(2%)	93	(7%)	231	(10%)	334	(8%)	32	(10%)	24	(8%)	30	(9%)	34	(10%)	32	(14%)
Asian/Pacific Islander	0	(0%)	1	(0%)	5	(0%)	6	(0%)	1	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
Asian	3	(1%)	25	(2%)	71	(3%)	99	(2%)	10	(3%)	7	(2%)	10	(3%)	12	(4%)	8	(4%)
Hawaiian/Pacific Islander	1	(0%)	0	(0%)	5	(0%)	6	(0%)	0	(0%)	6	(2%)	2	(1%)	0	(0%)	1	(0%)
Native American/Alaskan	5	(1%)	18	(1%)	39	(2%)	62	(2%)	5	(2%)	0	(0%)	6	(2%)	10	(3%)	3	(1%)
Multi-race	0	(0%)	2	(0%)	13	(1%)	15	(0%)	1	(0%)	4	(1%)	1	(0%)	6	(2%)	1	(0%)
Unknown	2	(0%)	7	(1%)	21	(1%)	30	(1%)	3	(1%)	2	(1%)	1	(0%)	3	(1%)	4	(2%)
Total	415	(100%)	1,354	(100%)	2,349	(100%	4,118	(100%	313	(100%	310	(100%	327	(100%)	339	(100%)	223	(100%
Exposure Category																		
Male/male sex (MSM)	282	(68%)	836	(62%)	1,455	(62%)	2,573	(62%)	192	(61%)	194	(63%)	206	(63%)	203	(60%)	125	(56%)
Injecting Drug Use (IDU)	44	(11%)	140	(10%)	203	(9%)	387	(9%)	25	(8%)	27	(9%)	25	(8%)	30	(9%)	17	(8%)
MSM and IDU	50	(12%)	115	(8%)	181	(8%)	346	(8%)	23	(7%)	28	(9%)	24	(7%)	26	(8%)	23	(10%)
Transfusion/Transplant	3	(1%)	7	(1%)	9	(0%)	19	(0%)	2	(1%)	1	(0%)	0	(0%)	2	(1%)	2	(1%)
Hemophilia	9	(2%)	4	(0%)	1	(0%)	14	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
Heterosexual Contact[6]	11	(3%)	131	(10%)	261	(11%)	403	(10%)	38	(12%)	40	(13%)	38	(12%)	34	(10%)	23	(10%)
Mother at Risk for HIV	3	(1%)	25	(2%)	7	(0%)	35	(1%)	0	(0%)	0	(0%)	1	(0%)	1	(0%)	0	(0%)
No Identified Risk[7]/Other	13	(3%)	96	(7%)	232	(10%)	341	(8%)	33	(11%)	20	(6%)	33	(10%)	43	(13%)	33	(15%)
Total	415	(100%)	1,354	(100%)	2,349	(100%	4,118	(100%	313	(100%	310	(100%	327	(100%)	339	(100%)	223	(100%
AIDSNET Region																		
Region 1	21	(5%)	54	(4%)	94	(4%)	169	(4%)	13	(4%)	16	(5%)	12	(4%)	18	(5%)	9	(4%)
Region 2	11	(3%)	42	(3%)	83	(4%)	136	(3%)	9	(3%)	14	(5%)	7	(2%)	11	(3%)	11	(5%)
Region 3	31	(7%)	123	(9%)	160	(7%)	314	(8%)	21	(7%)	16	(5%)	24	(7%)	23	(7%)	19	(9%)
Region 5	39	(9%)	166	(12%)	253	(11%)	458	(11%)	27	(9%)	37	(12%)	41	(13%)	25	(7%)	26	(12%)
Region 6	28	(7%)	112	(8%)	188	(8%)	328	(8%)	32	(10%)	23	(7%)	28	(9%)	29	(9%)	25	(11%)
Subtotal	130	(31%)	497	(37%)	778	(33%)	1,405	(34%)	102	(33%)	106	(34%)	112	(34%)	106	(31%)	90	(40%)
Region 4 (King Co.)	285	(69%)	857	(63%)	1,571	(67%)	2,713	(66%)	211	(67%)	204	(66%)	215	(66%)	233	(69%)	133	(60%)
Total	415	(100%)	1,354	(100%)	2,349	(100%	4,118	(100%	313	(100%	310	(100%	327	(100%)	339	(100%)	223	(100%

1 This includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. It does not include those who have only been tested anonymously for HIV.

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 7. WASHINGTON STATE AIDS CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 09/30/2005

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2001		2002		2003		2004[5]		2005 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	1,889	(97%)	5,695	(92%)	2,585	(85%)	10,169	(91%)	340	(88%)	341	(83%)	353	(84%)	330	(83%)	204	(84%)
Female	62	(3%)	493	(8%)	439	(15%)	994	(9%)	48	(12%)	71	(17%)	66	(16%)	68	(17%)	38	(16%)
Total	1,951	(100%)	6,188	(100%)	3,024	(100%)	11,163	(100%)	388	(100%)	412	(100%)	419	(100%)	398	(100%)	242	(100%)
Race/Ethnicity[10]																		
White, not Hispanic	1,710	(88%)	4,919	(79%)	1,999	(66%)	8,628	(77%)	249	(64%)	265	(64%)	269	(64%)	263	(66%)	149	(62%)
Black, not Hispanic	130	(7%)	605	(10%)	511	(17%)	1,246	(11%)	74	(19%)	74	(18%)	67	(16%)	65	(16%)	47	(19%)
Hispanic (All Races)	75	(4%)	417	(7%)	334	(11%)	826	(7%)	45	(12%)	42	(10%)	54	(13%)	42	(11%)	29	(12%)
Asian/Pacific Islander	3	(0%)	31	(1%)	11	(0%)	45	(0%)	3	(1%)	3	(1%)	1	(0%)	0	(0%)	1	(0%)
Asian	11	(1%)	68	(1%)	57	(2%)	136	(1%)	4	(1%)	13	(3%)	10	(2%)	9	(2%)	7	(3%)
Hawaiian/Pacific Islander	5	(0%)	9	(0%)	14	(0%)	28	(0%)	1	(0%)	2	(0%)	5	(1%)	2	(1%)	0	(0%)
Native American/Alaskan	16	(1%)	117	(2%)	74	(2%)	207	(2%)	10	(3%)	11	(3%)	0	(0%)	10	(3%)	1	(0%)
Multi-race	1	(0%)	20	(0%)	14	(0%)	35	(0%)	0	(0%)	1	(0%)	10	(2%)	5	(1%)	7	(3%)
Unknown	0	(0%)	2	(0%)	10	(0%)	12	(0%)	2	(1%)	1	(0%)	3	(1%)	2	(1%)	1	(0%)
Total	1,951	(100%)	6,188	(100%)	3,024	(100%)	11,163	(100%)	388	(100%)	412	(100%)	419	(100%)	398	(100%)	242	(100%)
Exposure Category																		
Male/male sex (MSM)	1,499	(77%)	4,224	(68%)	1,679	(56%)	7,402	(66%)	229	(59%)	219	(53%)	236	(56%)	209	(53%)	126	(52%)
Injecting Drug Use (IDU)	82	(4%)	573	(9%)	360	(12%)	1,015	(9%)	41	(11%)	47	(11%)	45	(11%)	43	(11%)	29	(12%)
MSM and IDU	234	(12%)	614	(10%)	260	(9%)	1,108	(10%)	32	(8%)	36	(9%)	33	(8%)	31	(8%)	27	(11%)
Transfusion/Transplant	47	(2%)	64	(1%)	12	(0%)	123	(1%)	0	(0%)	1	(0%)	1	(0%)	3	(1%)	0	(0%)
Hemophilia	30	(2%)	52	(1%)	9	(0%)	91	(1%)	1	(0%)	0	(0%)	1	(0%)	1	(0%)	1	(0%)
Heterosexual Contact[6]	29	(1%)	372	(6%)	376	(12%)	777	(7%)	50	(13%)	71	(17%)	56	(13%)	55	(14%)	32	(13%)
Mother at Risk for HIV	8	(0%)	18	(0%)	2	(0%)	28	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
No Identified Risk[7]/Other	22	(1%)	271	(4%)	326	(11%)	619	(6%)	35	(9%)	38	(9%)	47	(11%)	56	(14%)	27	(11%)
Total	1,951	(100%)	6,188	(100%)	3,024	(100%)	11,163	(100%)	388	(100%)	412	(100%)	419	(100%)	398	(100%)	242	(100%)
AIDSNET Region																		
Region 1	79	(4%)	343	(6%)	198	(7%)	620	(6%)	19	(5%)	26	(6%)	27	(6%)	29	(7%)	16	(7%)
Region 2	48	(2%)	191	(3%)	135	(4%)	374	(3%)	17	(4%)	15	(4%)	20	(5%)	23	(6%)	10	(4%)
Region 3	111	(6%)	514	(8%)	271	(9%)	896	(8%)	30	(8%)	40	(10%)	37	(9%)	37	(9%)	32	(13%)
Region 5	171	(9%)	645	(10%)	361	(12%)	1,177	(11%)	57	(15%)	37	(9%)	38	(9%)	45	(11%)	22	(9%)
Region 6	108	(6%)	531	(9%)	285	(9%)	924	(8%)	48	(12%)	48	(12%)	27	(6%)	41	(10%)	28	(12%)
Subtotal	517	(26%)	2,224	(36%)	1,250	(41%)	3,991	(36%)	171	(44%)	166	(40%)	149	(36%)	175	(44%)	108	(45%)
Region 4 (King Co.)	1,434	(74%)	3,964	(64%)	1,774	(59%)	7,172	(64%)	217	(56%)	246	(60%)	270	(64%)	223	(56%)	134	(55%)
Total	1,951	(100%)	6,188	(100%)	3,024	(100%)	11,163	(100%)	388	(100%)	412	(100%)	419	(100%)	398	(100%)	242	(100%)

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

* For explanation of revised AIDS total, see technical notes

WASHINGTON STATE REPORTED CASES OF CHLAMYDIA, GONORRHEA, EARLY SYPHILIS, JANUARY - SEPTEMBER 2005

	Chlamydia		Gonorrhea		Early Syphilis	
Sex	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Male	3,840	(27.5)	1,545	(56.8)	142	(96.6)
Female	10,119	(72.5)	1,175	(43.2)	5	(3.4)
TOTAL	**13,959**	**(100.0)**	**2,720**	**(100.0)**	**147**	**(100.0)**
Age						
0-14	171	(1.2)	20	(0.7)	0	(0.0)
15-19	4,382	(31.4)	532	(19.6)	4	(2.7)
20-24	5,296	(37.9)	762	(28.0)	20	(13.6)
25-29	2,152	(15.4)	456	(16.8)	12	(8.2)
30-34	862	(6.2)	299	(11.0)	20	(13.6)
35-39	457	(3.3)	240	(8.8)	42	(28.6)
40+	462	(3.3)	392	(14.4)	49	(33.3)
Unknown	177	(1.3)	19	(0.7)	0	(0.0)
TOTAL	**13,959**	**(100.0)**	**2,720**	**(100.0)**	**147**	**(100.0)**
Ethnic/Race						
White	6,196	(44.4)	1,116	(41.0)	109	(74.2)
Black	1,660	(11.9)	669	(24.6)	9	(6.1)
Hispanic	1,956	(14.0)	215	(7.9)	17	(11.6)
Native Hawaiian/Other Pacific Islander	137	(1.0)	14	(0.5)	1	(0.7)
Asian	494	(3.5)	57	(2.1)	4	(2.7)
Native American	415	(3.0)	69	(2.5)	1	(0.7)
Multi	393	(2.8)	60	(2.2)	3	(2.0)
Other	127	(0.9)	18	(0.7)	0	(0.0)
Unknown	2,581	(18.5)	502	(18.5)	3	(2.0)
TOTAL	**13,959**	**(100.0)**	**2,720**	**(100.0)**	**147**	**(100.0)**
Provider Type	**Cases**	**# Prov**	**Cases**	**# Prov**	**Cases**	**# Prov**
Community Health Ctr.	351	30	81	20	10	4
Emergency Care (Not Hosp.)	261	56	90	30	2	2
Family Planning	3,187	54	250	36	1	1
Health Plan/HMO's	615	42	98	26	4	3
Hospitals	1,244	86	432	64	10	10
Indian Health	155	20	37	10	0	0
Jail/Correction/Detention	634	40	181	29	3	3
Migrant Health	344	19	35	12	1	1
Military	584	9	68	5	3	1
Neighborhood Health	110	14	21	7	0	0
OB/GYN	935	116	70	41	0	0
Other	2,741	561	484	208	36	17
Private Physician	380	194	86	54	22	5
Reproductive Health	995	17	144	13	2	2
STD	945	29	579	15	52	2
Student Health	478	26	64	13	1	1
TOTAL	**13,959**	**1,313**	**2,720**	**583**	**147**	**52**

WASHINGTON STATE REPORTED STDS BY COUNTY JANUARY - SEPTEMBER 2005

	CT	GC	HERPES	P & S	EL	L/LL	CONG	TOTAL
Adams	22	3	1	0	0	0	-	0
Asotin	23	1	11	0	0	0	-	0
Benton	221	9	11	1	0	0	-	1
Chelan	93	3	10	0	0	0	-	0
Clallam	76	16	15	0	0	0	-	0
Clark	458	109	35	1	0	5	-	6
Columbia	3	1	0	0	0	0	-	0
Cowlitz	133	34	22	1	0	0	-	1
Douglas	29	1	10	1	0	0	-	1
Ferry	8	0	0	0	0	0	-	0
Franklin	117	4	3	1	0	1	-	2
Garfield	0	0	0	0	0	0	-	0
Grant	103	9	15	0	0	0	-	0
Grays Harbor	89	2	8	0	0	1	-	1
Island	105	8	20	3	0	1	-	4
Jefferson	41	1	5	0	0	0	-	0
King	2,920	831	409	87	36	55	-	178
Kitsap	338	33	35	3	1	3	-	7
Kittitas	81	5	5	0	0	0	-	0
Klickitat	16	3	0	0	0	0	-	0
Lewis	78	9	17	1	0	0	-	1
Lincoln	2	0	2	0	0	0	-	0
Mason	79	6	9	0	1	5	-	6
Okanogan	60	0	7	0	0	0	-	0
Pacific	13	1	2	0	0	0	-	0
Pend Oreille	6	1	2	0	0	0	-	0
Pierce	1,880	341	127	1	2	15	-	18
San Juan	5	0	0	1	0	0	-	1
Skagit	157	14	26	1	0	3	-	4
Skamania	5	3	0	0	0	0	-	0
Snohomish	818	117	144	3	0	9	-	12
Spokane	527	70	69	0	0	8	-	8
Stevens	37	1	3	0	0	0	-	0
Thurston	278	31	44	1	0	2	-	3
Wahkiakum	1	0	0	0	0	0	-	0
Walla Walla	88	1	8	0	0	1	-	1
Whatcom	256	49	38	0	0	2	-	2
Whitman	70	0	6	1	0	0	-	1
Yakima	496	70	47	0	0	3	-	3
YEAR TO DATE	9,732	1,787	1,166	107	40	114	0	261
PRV YR TO DATE	8,855	1,340	1,139	104	40	99	0	243
% CHANGE	9.9%	33.4%	2.4%	2.9%	0.0%	15.2%	NC	7.4%

CT = Chlamydia Trachomatis
GC = Gonorrhea
HERPES = Initial Genital Herpes
P/S = Primary & Secondary Syphilis
EL = Early Latent Syphilis
L/LL = Late/Late Latent Syphilis
CONG = Congenital Syphilis

MONTHLY TUBERCULOSIS CASE TOTALS BY COUNTY, 2004-2005

	JAN		FEB		MARCH		APRIL		MAY		JUNE		JULY		AUG		SEP		OCT		NOV		DEC		TOTAL	
COUNTY	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
Adams																									**0**	**0**
Asotin																									**0**	**0**
Benton			1						2										1						**4**	**0**
Chelan								1																	**0**	**1**
Clallam																									**0**	**0**
Clark		1		2	1	2			1		2					2			1		1		2		**8**	**7**
Columbia										1															**0**	**1**
Cowlitz																		1							**0**	**1**
Douglas																		1							**0**	**1**
Ferry																									**0**	**0**
Franklin			1						1			1		1	1										**3**	**2**
Garfield																									**0**	**0**
Grant								1								1									**0**	**2**
Grays Harbor						1								1									1		**1**	**2**
Island									1				1			1	2				1				**5**	**1**
Jefferson																									**0**	**0**
King	8	7	12	5	7	15	15	9	6	6	19	15	18	7	4	13	11	10	9		7		17		**133**	**87**
Kitsap				1				2		1			1			1							1	**2**	**5**
Kittitas							1																		**1**	**0**
Klickitat																									**0**	**0**
Lewis			1																						**1**	**0**
Lincoln																									**0**	**0**
Mason																							1		**1**	**0**
Okanogan																									**0**	**0**
Pacific																									**0**	**0**
Pend-Oreille																									**0**	**0**
Pierce	1	1	2	4	1		2	2	1	2	9	2	1	5	4	2	2	4	1		3		7		**34**	**22**
San Juan																	1								**1**	**0**
Skagit						1				1	1			3		1			1						**2**	**6**
Skamania																1									**0**	**1**
Snohomish		1		1		2			1		2		1	10	2	2	2	1	5		2				**15**	**17**
Spokane	3		1		1	4						1	1					1					1		**7**	**6**
Stevens																		1							**0**	**1**
Thurston		2	1						1	1	1						1	1	3						**7**	**4**
Wahkiakum																									**0**	**0**
Walla Walla						1										1			1						**1**	**2**
Whatcom	1	1		1	1		1	1			1			1					2						**6**	**4**
Whitman						1																			**0**	**1**
Yakima	2	1	3	1			1	2	1	1		2	1	4			2		1				1		**12**	**11**
State Total	**15**	**14**	**22**	**15**	**11**	**27**	**20**	**18**	**15**	**13**	**35**	**21**	**24**	**32**	**11**	**25**	**21**	**20**	**25**	**0**	**14**	**0**	**31**	**0**	**244**	**185**
YTD State Total		**14**	**37**	**29**	**48**	**56**	**68**	**74**	**83**	**87**	**118**	**108**	**142**	**140**	**153**	**165**	**174**	**185**	**199**	**185**	**213**	**185**	**244**	**185**	**244**	**185**

Note: Detailed analysis of tuberculosis morbidity is contained in "Washington State Tuberculosis Epidemiological Profile - 2002" and is available to order from the State TB Program by calling (360) 236-3443.

Deadline Details For *Washington State Responds* Quarterly Newsletter

The deadline for the next issue of ***Washington State Responds*** is **December 20, 2005**. The calendar start date for the issue is **February 5, 2005**. To submit information, corrections, or to be added or dropped from the mailing list, contact Barbara Schuler, Washington State Department of Health, HIV Prevention and Education Services, P.O. Box 47840, Olympia, WA 98504-7840. You may also telephone her at: (360) 236-3487 or call the Washington State Hotline at **1-800-272-2437, ext. 0** to leave a message**.** You may fax your information to (360) 236-3400, or preferably send via e-mail to: barbara.schuler@ doh.wa.gov

We greatly appreciate news of your work or your organization!

Thank you for taking the time and effort to write, call, fax or e-mail!

DOH HIV/AIDS PREVENTION AND EDUCATION SERVICES

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This newsletter may contain HIV prevention messages that may not be appropriate for all audiences. Since HIV infection is spread primarily through sexual practices or by sharing syringe needles, prevention messages and programs may address these topics. If you are not seeking such information or are offended by such materials, do not visit this site.